INTERNATIONAL CONFERENCE

ON

WELFARE OF WOMEN AND FERTILITY AWARENESS

JANUARY 10 TO 12

IN THE

YEAR OF THE GIRL CHILD 1990

AT

ST. JOHN'S MEDICAL COLLEGE & HOSPITAL
BANGALORE

PROCEEDINGS

02812

GIRL CHILD SURVIVAL

ource : Meera Chatterjee, Both Gender and Age Against Them : Mimeo Report, NIPCCD, New Delhi, 1988.

INTERNATIONAL CONFERENCE

ON

WELFARE OF WOMEN

AND

FERTILITY AWARENESS

JANUARY 10 TO 12

IN THE

YEAR OF THE GIRL CHILD 1990

AT

ST. JOHN'S MEDICAL COLLEGE & HOSPITAL
BANGALORE

PROCEEDINGS

INTRODUCTION

The 'International Conference on Welfare of Women and Fertility Awareness' which we arranged here in St. John's Medical College and Hospital Campus on the 10 - 12 January 1990 was one of our contributions to the celebration of the SAARC Year of the Girl Child (1990).We timed this contribution for the commencement of the year, because whatever we presented, through the participants, in the way of expert knowledge of the problems of the girl child, particularly in the developing countries, could be of some use for the consideration given to the solutions of the problems by various bodies in the course of the year, and in the years to come. In order to facilitate this consideration, we have brought out this brochure which contains a comprehensive record of the proceedings of the Conference.

Dr.(Sr.) Agostina Thomas
Head of the Department of
Family Welfare & Fertility Study
St. John's Medical College and Hospital
Bangalore

Dr.(Fr.)Percival Fernandes
Director
St. John's Medical College and Hospital
Bangalore

Bangalore.
5th March 1990.

CONTENTS

MESSAGES

Greetings to all who are taking part in the International Conference at Bangalore on the important theme "Welfare of Women and Fertility Awareness".

The Conference places Natural Family Planning in an important human context - the well being of woman in body,mind and soul. In 1990, the Year of the Girl Child, let us all clearly proclaim the truth and justice of the proper use of natural child spacing, because this is a sure way of authentic liberation for all women in their child bearing years.

How can fertility awareness be "liberating"? We do not think in terms of freeing women from the supposed "burden" of childbirth, a destructive myth in western societies. Rather, we have learnt that fertility awareness is the lifting of the burden of the methods of contraception, sterilization and abortion, placed first and foremost on women. With side effects in health and personal anguish, that burden is imposed by forces committed to the false dogmas of population control. With little regard for the sacred right to life, for women's rights and their health, for ethics, for religions and ethnic traditions of the family, the forces of population control imagine, they solve social problems by cropping back people.

The Conference will offer women a better way! It will offer women the right way! It will offer women the accurate guidance to the secrets of their fertility - and they have a right to this information. It will offer health to mothers and their babies. We must not be discouraged by the apparent power of those who offer false solutions. God goes with us in our work. The truth of His Spirit is active in and through us ; by our faith and patience, by our closeness to the humblest ones of this world, the victory of His Kingdom will surely be ours!

The Pontifical Council for the Family sends every blessing for the Conference participants.

Vatican City State
15 December 1989

+Edouard Cardinal Gagnon, P.S.S.
President of the Pontifical Council
for the Family

The Prime Minister is happy to learn that St. John's Medical College Hospital, Bangalore, is hosting a conference on the "Welfare of Women and Fertility Awareness" from 10th to 12th January, 1990. He sends his best wishes for the success of the conference.

New Delhi
26 December 1989

Ajoy Acharya
Deputy Secretary to the
Prime Minister

May God's blessings abide with St. John's Medical College and Hospital always, and especially during the days of the conference on Welfare of Women and Fertility Awareness. May many young people come to know Jesus's personal love for them through it, and keep the good news of His love alive in the world by loving others as He loves them.

Calcutta
5th August 1989

Mother Teresa, MC

The prejudices prevalent against women, and the way they are treated in private and in public, are a sorry comment on our modern culture and enlightenment. From the moment of birth the girl-child is subjected to indignities,rejection,discrimination,physical abuse and even rape, when, on the contrary, as bearer of life she ought to be surrounded with loving protection, cherished and honoured,and her rights respected.

It is my sincere hope and prayer that the INTERNATIONAL CONFERENCE ON WELFARE OF WOMEN AND FERTILITY AWARENESS will focus on what should be the great honour for a woman but which in practice proves a great handicap in life.

I wish the Conference succession every way and assure the organisers and participants of my prayers and Blessing.

Bombay
13 December 1989

+ Simon Cardinal Pimenta
Archbishop of Bombay

I am immensely happy to know of the International Conference on "Welfare of Women and Fertility Awareness" under the auspices of the C.B.C.I.Society for Medical Education and I wish it every success. May the deliberations of the conference lead to greater focus on the problems of women and children and evolve effective means to solve them.

I invoke God's blessings on the conference.

Ernakulam
13 December 1989

+Anthony Cardinal Padiyara
Archbishop of Ernakulam

I am happy to know that the International Conference on "Welfare of Women and Fertility Awareness" is being organized on the occasion of the Year of the Girl Child.

I send my best wishes to the organisers of the Conference and assure them of my prayers.

Trivandrum
11 December 1989

+ Benedict Mar Gregorios
Archbishop of Trivandrum

I am glad to know that St.John's Medical College and Hospital,Bangalore, is holding an International Conference on "Welfare of Women and Fertility Awareness" from January 10 to 12, 1990

The regulation of fertility and birth by choice is one of the most crucial factors connected with status of women in any society. Moreover safeguarding reproductive health is very basic to their well being. We have to find effective ways and means to improve women's literacy and bring about the much needed awareness among the women themselves and society at large. Then alone can the plight and suffering of the girl child be taken care of and her rights be safeguarded.

I hope this Conference would focus attention on these important issues.

New Delhi
30 December 1989

Nilamani Routray
Minister of health & Family Welfare
Government of India

I congratulate the St. John's Medical College and Hospital authorities and Dr. Sr. Agostina Thomas for organising the International Conference on Welfare of Women and Fertility Awareness. The subject chosen is very relevant and topical for the year 1990. being the year of the Girl Child.

I am sure, with the imposing list of such distinguished speakers as have agreed to take part in the conference, it will be of great interest and usefulness, and will be appreciated by all.

I wish the conference God's blessings and all success.

Bellary
20 Dec. 1989

+Ambrose P. Yeddanapalli ,O.F.M.,
Bishop of Bellary

On the occasion of the International Conference on welfare of Women and Fertility Awareness, and also on the occasion of the year of the Girl Child, I send you my warm greetings to the participants and the assurance of my prayers for the success of this meeting.

May God continue to guide Dr. Sr. Agostino Thomas and her associates in their good work.

Lucknow
30 December 1989

+Alan de Lastic
Bishop of Lucknow

I thank the management,Principal and the staff for their kind invitation to the inauguration of the International Conference on Welfare of Women and Fertility Awareness. We,in this Diocese, wish the Conference every success in alleviating the sufferings of women and upholding the teachings of the church.

Our prayerful good wishes and kind regards to all the participants of the conference.

Bareilly
23 December 1989

+Anthony Fernandes
Bishop of Bareilly

FROM THE DIRECTOR'S DESK

It is with joy that I write these few lines for the brochure containing the proceedings of the International Conference on Welfare of Women and Fertility Awareness held in the Campus of St. John's Medical College & Hospital with outstanding success from January 10 to 12, 1990. The theme of the Conference is very relevant for our times, focussing, as it does, the attention of men and women of goodwill on natural methods available to plan their families.

My cheers and gratitude to all who bore the burden of organizing this Conference under the leadership of our Department of Family Welfare & Fertility Studies, which is one of the youngest departments of this institution and which, I trust, will, in the not-so-distant future, develop into a national centre for the promotion of the welfare of women in the sphere of fertility and family planning.

I do believe that the contents of this brochure, the pages of it are replete with practical knowledge, will remain as a monument to the excellence of the Conference, and as a valuable aid to the study of the theme of the Conference.

(Fr.) Percival Fernandez
Director
St. John's Medical College and Hospital
Bangalore.

25th February 1990.

HOW THE INTERNATIONAL CONFERENCE ON WELFARE OF WOMEN & FERTILITY AWARENESS CAME TO BE

By Dr. Sr. Agostina Thomas, Head of the Department of Family Welfare and Fertility Study.

1. The Department of Family Welfare & Fertility Study in St. John's Medical College and Hospital, Bangalore conducts workshops every year on Responsible Parenthood and Respect for Life, on the national level. As we were contemplating one such programme for the year 1990 in the early months of 1989. Mrs. Mary Shivanandan from the U.S.A. who was visiting Bangalore, stopped here for a friendly chat. On hearing about our plan, she graciously offered to help plan the workshop for 1990. She also mentioned, as 1990 was to be declared "The Year of the Girl Child" by SAARC, we could highlight the conditions of girl children too. She visited with us for three days, and introduced the names of some would be speakers and benefactors, who would help us to host the Workshop.

2. As our Department went about in the following months Plannning and Organising, the event took the shape of a Conference, and an International one later, as more and more people from other neighbouring countries (SAARC) started showing interest in the conference.

3. In keeping with the theme, and the commitment of St. John's Medical College and Hospital, Bangalore, to promote Family Welfare and Respect for life, the International Conference was organised from 10 to 12 January 1990 to focus on the Welfare of Women and Fertility Awareness, in collaboration with the Department of Obstetrics and Gynaecology.

4. Speakers of International repute in the field from India and abroad were invited to present papers. Eminent doctors, senior educationists and representatives of various social and welfare organisations, came forward to register as participants. The social and cultural problems of Women of South Asian Countries appeared to be similar.

5. In a culture that idolizes sons and dreads the birth of a daughter, to be born a female is to be born less priviliged. The rejection of the unwanted girl begins even before her birth and prenatal sex determination, is invariably followed by quick abortion of the female fetuses. The girl who escapes this prenatal destruction is generally relegated to an inferior position in the family and is looked upon as the lesser child in our society. The proposed Conference was aimed at focussing on these various issues in order to outline what needs to be done to stem the tide of adverse attitudes towards women and girl children.

6. Further, in India, where child spacing is important, men do not come forward to submit themselves to methods of Family Planning that have side effects. Physical or emotional, on the pretext that they have to work hard to support the family, thus in effect almost always forcing the women to adopt various methods of birth control. The World is moving fast towards nature and natural methods and home remedies in treating various diseases. Accordingly, this conference also provided a forum by which pioneers in the field of natural methods of

Family Planning elaborated on the very safe, inexpensive and yet scientific methods to space child birth and to limit the size of the family which is the combined responsibility of the couple.

7. There was an overwhelming response to the first information sent out. About 240 delegates registered themselves and many offered to present short papers. We could accept only about a dozen papers.

8. The Principals of several outstanding schools, encouraged their students to take part in the 'Teenage Programme' where the youngsters were to deliver short speeches.

9. Throughout the period of the planning and organising, especially in the last four months before the Conference the Planning Committee consisting of the Director, the Administrator of the Hospital, the Principal, the Medical Superintendent, the Deputy Administrator and Professors and Heads of several departments collaborated and gave full support. During the last month, the Chairpersons of the various committees worked hard to make the arrangements a success.

10. The generous help offered by UNFPA, Misereor, Caritas India, UNICEF and the UGC through the Bangalore University went a long way to meet the expenses and was thus instrumental in making the Conference a success.

PLAN YOUR FAMILY IN NATURAL WAY

To live with our bodies, and not in spite of them, is a discovery our "Civilized" world is just now making. An old Asian Wisdom maintains that perfectionist only acquired through the mastery of the body. The more one is able to live with his or her own body and master its nature, the freer is one's mind and the wider the horizons. An African chief told me recently, when describing the period of abstinence required for couples in his tribe after the birth of a child (sometimes until the baby can walk or even longer), "A REAL MAN IS ONE WHO CAN WAIT. ONLY A CHILD TAKES WHAT HE WANTS WHEN HE WANTS IT !"

Ingrid Trobisch

PROGRAMME

Wednesday, 10th January, 1990

9.00 a.m. - 10.00 a.m : **INAUGURAL FUNCTION**

10.00 a.m. - 10.30 a.m : Refreshments

10.30 a.m - 11.00 a.m : **"The year of the Girl Child"**
Keynote Address :
Mrs. Meena Saksena IAS
Director, Welfare of Women and Children.
Chair Person : ***Dr. Thangam Joseph,*** Prof. & Head
Dept. of Pharmacology, SJMC

11.00 a.m - 12.20 p.m. : **"Symposium on Welfare of Women"**
Chair Person : ***Dr. Manorama Thomas,*** Prof. & Head Dept. of Anatomy & Genetics, SJMC

A : Gandhi's Vision for Women
Speaker: ***Dr. Ila Naik.*** Asst.Director, Adult & Cont.Educ.
Gujarat Vidyapith, Ahmedabad.

B : Population Education
Speaker : ***Prof. Desai***
Gandhi University. Ahmedabad

C : The Dignity of Women - an ethical concern.
Speaker: ***Dr. Fr.T.Kalam,***
Prof.of Bioethics, SJMC

12.20 p.m. - 1.00 p.m. : **"Caring for the Girl Child"**
Speaker: ***PADMABHUSHAN Dr. Tirumala Rao***. Prof. of Paediatrics, Gandhi Medical College Hospital, Hyderabad
Chair Person; ***Dr. M.K. Chandrashekara,*** Prof. & Head. Paed.Dept. SJMCH

1.00 p.m. - 2.00 p.m. : Lunch

2.00 p.m. - 2.40 p.m. : **"The Wellness Approach to Mother & Child"**
Speaker : ***Mary Shivanandan,***
Director, K.M.Associates,
Mary Land, U.S.A
Chair Person : ***Dr. Moire Jacob,***
Assoc. Prof. of Medicine, SJMCH

2.40 p.m. - 3.20 p.m. : **" Nutrition in Adolescents"**
Speaker : ***Dr.Doren Frederickson***
Chair Person : ***Dr. Prem Pais,***
Prof. of Medicines, SJMCH

3.20 p.m. - 3.40 p.m. : Tea

3.40 p.m. - 4.40 p.m. : **Short Papers**
Chair Person : ***Dr. Aloma Lobo,***
Director
Family Welfare Centre, Bangalore

4.40 p.m. - 5.00 p.m. : 15 mnts. Video Film - 6 Nakisha's : 6 spots on Girl Child

Thursday, 11th January, 1990

9.00 a.m. - 9.40 a.m. : **" Key Note Address"**
Speaker: ***Dr. John Billings.***
Prof. Emeritus of Neurology,
University of Melbourne & President of WOOMB. Australia.
Chair Person : ***Dr. Sr. Agostina Thomas,***
Head. Dept. of Family Welfare & Fertility Study. SJMCH

9.40 a.m. - 10.00 a.m. : **" NFP work in St. John's"**
Speaker : ***Dr. Sr. Agostina Thomas***
Chair Person : ***Dr. Alfred Mascarenhas,***
Principal, SJMC

10.00 a.m - 10.20 a.m : Refreshments

10.20 a.m. -11.00 a.m. : **" Pilot Studies on NFP in the Public Sector in India"**
Dr. Badri Saxena, Senior Dy. Director General, ICMR, New Delhi
[Paper read by Dr. R. Narayanan]

11.00 a.m. - 11.40 a.m. : **" Cross Cultural Studies in NFP"**
Speaker : ***Dr. Hanna Klaus,***
Exec. Director NFP Centre of Washington DC, U.S.A.
Chair Person : ***Dr. Dara Amar,***
Prof. & Head Dept. of Community Medicine, SJMC

11.40 a.m. - 12.20 p.m. : **" Infertility- Male & Female- Causes and role of NFP in achieving pregnancy"**
Speaker : ***Dr. R.Narayanan,***
Prof. & Head of the OB & GYN. SJMCH
Chair Person : ***Dr. Sridhar,***
Prof.Dept. of Medicine, SJMCH

12.20 p.m - 1.00 p.m. : **Film : Billings Ovulation Method**

1.00 p.m. - 2.00 p.m. : Lunch

2.00 p.m. - 2.50 p.m. : **1. " Chromosomal Anamolies in Infertility**
Speaker : ***Dr. Manorama Thomas,***
Prof. & Head. Dept. of Anatomy & Genetics, SJMC

2. " Cervical Mucus & BBT in treatment of Infertility Cases"
Speaker : ***Dr. Lillian***, Assoc. Prof.
Dept. of OB & GYN. SJMCH

3. " Field Experience in teaching NFP"
Speaker : ***Dr. Dara Amar***
Chair Person : ***Dr. R. Narayanan.***

2.50 p.m. - 3.30 p.m. : **"Fertility Awareness and its use - an entry point on Women development"**
Speaker : ***Dr. Kathleen Dorairaj***, Exec. Director/Consultant, NFPAI, New Delhi.
Chair Person : ***Dr. A.N. Balasundaram.***
Prof. & Head. Dept. of Medicine, SJMCH

3.30 p.m. - 3.50 p.m. : Tea

3.50 p.m. - 5.00 p.m. : **Short Papers**
Chair Person : ***Dr. Rita Mashkar,***
Dept. of OB & GYN. SJMCH.

7.15 p.m. : **Cultural Programme**

8.15 p.m. : **Banquet**

Friday, 12th January, 1990

9.00 a.m. - 9.40 a.m. : **" NFP in the 21st Century"**
Guest Speaker : ***Dr. Claude Lanctot.***
Director, IFFLP, Washington. U.S.A.
Chair Person : ***Dr. Sr. Lillian***

9.40.a.m. - 10.20 a.m. : **" Welfare of Women & Family Planning in the Asian Context"**
Speaker : ***Dr.SR. Catherine Bernard,***
Director, SERFAC, Madras
Chair Person : ***Dr. Malathi Yeshwanth***

10.20 a.m. - 10.35 a.m. : Refreshments

10.35 a.m. - 11.15 a.m. : **" Child Spacing through Breast Feeding"**
Speaker : ***Dr. R. Jackson,***
Prof. of Paediatrics
University of Kansas, U.S.A.
Chair Person : ***Dr. Raghuveer,***
Asst.Prof. of Paediatrics. SJMCH

11.15 a.m. - 11.55 a.m. : **" The Indian Family at the Cross Road"**
Speaker : ***Dr. Marie Mascarenhas,***
Director, CREST
Chair Person : ***Dr. Mario De Souza,***
Dy.Administrator, SJMCH

11.55 a.m. - 1.00 p.m : **Interaction**

1.00 p.m. - 2.00 p.m. : Lunch

2.00 p.m. - 2.30 p.m. : **Symposium - Teenage Speakers**

2.30 p.m. - 3.00 p.m. : **" SAARC" members meet**
Chair Person : ***Mrs. Padma Rama-chandran*** , IAS, Trivandrum

3.00 p.m. - 4.00 p.m. : **General Session**

4.00 p.m. - 4.15 p.m. : Tea

4.15 p.m. - 5.00 p.m. : **Valedictory Function**
Vote of Thanks -
Dr. Sr. Agostina Thomas

INAUGURAL FUNCTION OF THE CONFERENCE:

The Inaugural Function of the International Conference of Women's Welfare and Fertility Awareness was held on January 10, 1990 at 9.00 A.M. in the Anatomy Hall of St. John's Medical College and Hospital, Bangalore.

2. The Honourable Shri. Veerendra Patil, Chief Minister of Karnataka State, India, was the Chief Guest and Most Rev.Dr.Alphonsus Mathias, President of the Catholic Bishop's Conference of India and Archbishop of Bangalore presided over the function.

3. An Invocation Song was rendered by the students of the St. John's College of Nursing at the commencement of the function.

4. Rev.Dr.(Fr.) Percival Fernandez, Director of St.John's Medical College and Hospital, gave the address of welcome, in the course of which he said that the Honourable Chief Minister had seen the institution of St. John's grow from its infancy. and that he would be proud of the fact that, situated as it is in his State, it was now counted among the best teaching Medical Colleges and Hospitals in the country. Fr.Fernandez availed himself of the opportunity to invite the Chief Minister's attention to the application for grant to the institution of permanent affiliation to the Bangalore University, which had been pending for some years, in the Department of Health of his Government; the great deal of energy now being spent in the institution in pursuing the application could be utilized for quality teaching and service.

5. Welcoming His Grace Alphonsus Mathias, Fr.Fernandez said Archbishop Mathias had been actively involved in the development of the institution for some years; the institution was confident that under his stewardship as the president of the Catholic Bishop's Conference of India, it will achieve greater progress, particularly in the orientation of its education and health care services to the needs of the underprivileged in the country.

6. Turning to Dr. John Billings, founder of the "World Organisation of the Ovulation Method of Billings" (WOOMB) Fr. Fernandez said, Dr. Billings had the institution of St. John's close to his heart; the Conference would gladden him in many ways as it was aimed at promoting the great human need of the proper planning of families. The participation of Dr.Claude Lanctot, Executive Director of the International Federation of Family Life Promotion (IFFLP) was a source of encouragement to St. John's which was grateful to him, he should have made it possible to attend the Conference despite his many other commitments. Mrs.Mary Shivanandan, Fr. Fernandez said, was the one from whom St. John's drew the inspiration to organize the Conference in the SAARC Year of the Girl Child.

7. Fr.Fernandez then briefly outlined the messages of appreciation of the project of holding the Conference, which had been received from Church and State dignitaries.(The text of these messages appear in this brochure).

8. Speaking next, Dr.Alfred Mascarrenhas, Principal of the college explained the objectives set for the College and the Hospital in the background of their history. Starting in the temporary, loaned and cramped premises of St. Mary's Or-

phanage in Cooke Town of the Bangalore City in July 1963, and initiating its clinical studies in St. Martha's Hospital (run by the Sisters of the Good Shepherd) it had moved to the present 150 acre campus in 1968.

9. The central objective of the institution had been spelt out by the Catholic Bishops' Conference of India, as the training of young men and women to be health professionals imbued with the spirit of Christ, who would devote themselves to the underprivileged in the country and in other situations. For the fulfilment of this aim, the campus today is equipped not only with a Medical College but also a Hospital of Nursing, and an Institute of Health Care Administration and an Institute of community Health Workers; several other courses have also been undertaken, e.g., a course on Pastoral Medicine and Pastoral Care. A sustained emphasis has been placed in the training, on inculcation of the value of the human person, with its focus on Respect for life from the moment of conception. There is a seperate Department of Ethics in which special courses are given in Medical Ethics and Bioethics.

10. The vast and spreading Hospital provides not only the basic services but also comprehensive specialities and super-specialities including among others, Open Heart Surgery, Renal Transplantation, Immuno-Chemistry, Immunology, Radio-immuno Assay, and Gastro-enterlogy. There is a seperate Department which provides counselling and technical service in Natural Family Planning and in cases of infertility. No one is turned away for not being able to afford the cost of treatment.

11. The services available, Dr. Mascarrenhas said, are not limited to the campus of St. John's. A wide network has been created of very committed people who are working, day in and day out, in "Community Health", not only in Public Health Centre areas (e.g.,Dommasandra, Anekal and Bidthi in the Karnataka State) but also in many other situations such as the Coffee, Tea and other plantations in south India, where services have been established in occupational Health in various small and remote villages with, e.g.,trained guides. A remarkable feature of the activities is, that it is not only Religious Sisters (as doctors and nurses) who are engaged in them, but also some laymen and laywomen who, after undergoing a compulsory course in rural training, have made a deliberate decision to settle down to a regular career of service in underprivileged areas (rural and urban) in the country.

12. The institution has acquired a national and international status. The students have distinguished themselves in curricular and extra-curricular activities, and in games and sports. Among its laurels are Rhodes scholars and alumni heading departments in prestigious health organisations such as the National Institute of Health at Bethesda, Maryland, USA and as Chairmen of departments in various universities in different parts of the world.

13. Dr. Mascarenhas concluded his speech by pointing out that the students and the staff derive their inspiration from the institution's Emblem and Motto - "He shall live because of Me" - in which "He" stands for the patient and "Me" for Christ, the Divine Healer.

14. Rev.Fr.Bernard Moras, Administrator of the Hospital, spoke in technical detail on the education and service offered by the institution in its Department of Family Welfare and Fertility Study in the all-important field of family planning and family welfare. His speech appears in full in this brochure.

15. The theme of the Conference - "Welfare of Women and Fertility Awareness" - which was directed to reinforce the fight against evil practices the Girl-Child is subjected to, such as female foeticide, dowry and brideburning, was introduced by Dr. Sr.Agostina Thomas, Convenor of the Conference. and Head of the Department of Family Welfare and Fertility Study. 1990 had been declared by the SAARC as the "Year of the Girl Child"; India has 140 millions girls below 20 years of age. A study of 8000 abortions conducted after amiocentesis, in a certain city showed that 7,999 of the aborted foetuses were female. Sr.Agostina Thomas stressed that continued indifference towards women and girls would have amost serious adverse influence on India's developmental goals, which the nation cannot afford.

16. The Hon'ble Shri. Veerendra Patil, Chief Minister of Karnataka and the Chief Guest at the function, then lit the Indian traditional lamp. In the course of his speech, which followed, he said that socio-economic compulsions for female foeticide and infanticide could perhaps be eliminated by educating women so as to ensure greater economic independence for them; the old age pension scheme should be modified so the couples would not be inclined to opt for sons for financial reasons. It was unfortunate that there was a general lack of awareness about the need to reform society's attitude towards women. The Chief Minister's observations set the tenor for the deliberations of the Conference.

17. The Most Rev.Alphonsus Mathias, President, Catholic Bishops' Conference of India, who presided at the function said that the attitude of intolerance and violence spreading in the country had to be checked; this was responsible, together with lack of respect for life, for the mounting number of abortions in the country. The well-springs of life had to be protected.

18. Dr. John Billings, Founder-Director of the World Organisation of the Ovulation Method of Billing (WOOMB) and Dr.Claude Lanctot, Executive Director of the International Federation for Family Life Promotion, also addressed the gathering.

19. The function concluded with Dr. Manorama Thomas, Professor and Head of the Department of Anatomy in St. John's, proposing the vote of thanks, and with the singing of the Indian National Anthem.

The Participants - at the International Conference on 10-1-90

The Chief Minister Shri Veerendra Patil
Lighting the lamp and
Inaugurating the conference.

Inaugural Function - The Dignataries on the Dais

The Director updating the Chief Minister on the activities of St. John's

Dr. Billings receive a memento from Dr. Sr. Agostina Thomas

Mrs. Meera Saksena IAS delivering keynote address on the "Year of the Girl Child"

The Dept. of Family Welfare and Fertility Study with the Administrator

FAMILY WELFARE ACTIVITIES AT ST.JOHN'S

Speech by Dr. Bernard Moras, Administrator of St. John's Medical College and Hospital.

The Government of India over the past years has drawn up a Family Welfare and Planning Programme throughout the country, in view of its concern over the growing population of India. However, while planning to solve the population problem it is necessary to remember that we are not dealing with things, but with men and women, and we must never forget this crucial fact, even though we may be tempted to do so, when the population data are presented. In view of this, the Ministry of Health and Family Welfare of Government of India has developed a 13 point programme including:

1. Proper spacing and limitation of birth.
2. Education for parenthood.
3. Marriage counselling.
4. Preparation of the couple for the arrival of children.

There is ample room for the Church and for Christians to collaborate with most of these programmes.

The Catholic Church in India has been always concerned about the welfare of the family which, though it is the smallest, is the strongest unit of any nation or any society. The church has been always actively engaged, in the field of family welfare activities, especially through its various programmes and projects, aimed at delivering family life services in an integrated way, to include Family Life, Education, Marriage preparation, Natural Family Planning, Family Counselling, an Infertility Clinic, Respect for Life, and Community Health which includes immunization and antenatal care of mother and child. Some of the major centres in India under the auspices of the Church, have taken up several research studies in Family Welfare and Natural Family Planning, and have presented their findings to various world bodies like the WHO and to Indian scientific bodies such as the Indian Council of Medical Research.

The Medical college is basically an agent for education, research and service, the institution through which various persons are taught, to achieve the health of the family and the society as a whole. Family health is the essence in planning a healthy society. Keeping this in mind, St. John's Medical College and Hospital has been engaged from its very inception, to plan, and to help plan, healthy and happy families, through health education at the college and the Hospital, with special reference to rural India, which lives in close intimacy and feels at home, with nature, and hence using natural means, wherever Family Planning and Family Welfare Services are required to form an integral part of activities in this institution. Education holds the key to the population problem of India today, by creating an awareness of it problems and of its effects on the family, which will produce results, though slow, but more permanent and enduring. Success of any policy depend upon volition of people, which results from their consciousness, either positive or negative. The need has been expressed at various meetings for St.John's Medical College and Hospital to set up a separate Department of Family Welfare and Fertility Study and to make St. John's the leading centre in the whole of the country. As the only Catholic medical college in India, it is its duty to develop, upgrade and function actively in this field and give a direction, under the auspices of the

Catholic Church, to the rest of the country.

At the meeting of the Executive Committee of the Governing Board of the C.B.C.I. Society for Medical Education held in August 1983, a decision was taken to set up Natural Family Planning Services in a formal way at the St. John's Campus Hospital and Dr.(Sr.) Lillian, Associate professor of Obstetrics and Gynaecology was put in charge of the Department and its services. The Department was specially called as "Family Welfare", as it is expected of the Department to take care of the comprehensive health of the family. At present Dr.(Sr.) Agostina Thomas is heading the department, under its new name "Department of Family Welfare and fertility Study" which was given to it to cover the wider and comprehensive aspects of the family welfare, including rendering of services even to those couples who are infertile.

The Department is actively engaged today in providing services in Family Life, Education and Natural Family Planning to all inpatients and outpatients. It also undertakes Research and Documentation. A detailed plan is drawn up and implemented with regard tothe education, training and service.All the staff and students of the college and Hospital, including medical students and nursing students, are exposed to Natural Family Planning and detailed courses have been conducted,for each and every one of them, in groups or individually, at different stage of their studies from the time of their entering the College or Hospital till their interships. Both in patients and outpatients of the department of Obstetrics and Gynaecology are contacted, helped and followed up, with mother and child care and comprehensive family welfare services, including Natural Family Planning, through various talks, audio-visual aids, etc., the results have been very encouraging and rewarding.

St. John's has taken up a large area for its Community Health Extension Work. This is the only medical college in India having such a large Community Health Workers training programme and extension work. And the Department of Family Welfare and Fertility Study, in close collaboration with the Department of Community Health is implementing family welfare services in all these extension areas.

Besides its services in the Hospital to the staff, students, patients and to the community, the Department with the assistance of Department of Obstetrics and Gynaecology and the Community Health Department is actively involved in organising family welfare service training programme for trainees in the form of workshops and seminars. We have been engaged in organising exhibitions on Respect for Life and Workshop on Family Welfare, Responsible Parenthood and NFP and the response has been so overwhelming that the demand to be met has been beyond our available means and facilities. Hence the College and the Hospital are looking forward to the growth of the Department so as to be able to serve the community in a better way.

The department of Obstetrics and Gynaecology is also involved in research in collaboration with the Family Welfare and Fertility Study. It has worked out a project titled "Scope of successful practice of Ovulation Method in Postpartum, Breast-feeding Women",the aim being to evaluate the feasibility of successful practice of the Ovulation Method of Family Planning in this group of women.

I am happy to announce that the Catholic Bishop's Conference of India which met at shillong in lthe month of November last year, after reviewing the activities of St. John's and in particular that of the Department of family Welfare and Fertility Study have pronounced it be a National Effort of the Church in India, to be

encouraged and supported by all. There had been even a talk in the past, that St.John's should set up a Centre for Family Life Services and Research, in the context of the problem the Church is facing with regard to the 'Family' in the modern world, and I feel sure the Department of Family Welfare and Fertility study at St.John's would one day, only grow into a full fledged department much stronger that what it is today, but also into an Institute or a Centre of Family Life Service and Research.

" Women, you are blest,
you have taken upon yourself the creator's work
and are his helper
You open the way to recovery
and ever renew the outworn world.
Quietly, bravely, in beauty's form
you carry with in you
the preserving force of the Universe
and for the fallen, the broken, the deformed
the gracious touch of the lovely one".

- Rabindranath Tagore

INTRODUCTION OF THE THEME OF THE CONFERENCE

By Dr. (Sr.) Agostina Thomas.

It is my pleasure and privilege to introduce the theme of the Conference to you this morning. It might appear at the very outset, that the Conference has two themes. Not so; it has two aspects to it. The Welfare of Women and Fertility Awareness are closely linked. All those who are concerned with uplifting the status of girls and women should appreciate this fact. It is important for women to know the facts of their reproductive biology - or at least the fact that they are fertile only a few days in a month, so that they could use this knowledge either to achieve or avoid pregnancy. With this awareness, our women need not limit their choices regarding themselves, their bodies or their family life. How closely these two aspects of the theme are related is brought out by the Central Health Minister, Mr. Nilamani Routray, in his message to the Conference. He says:

> "The regulation of fertility and birth by choice is one of the most crucial factors connected with status of women in any society. Moreover, safegaurding reproductive health is very basic to their well-being. We have to find effective ways and means to improve women's literacy, and bring about the much needed awareness among the women themselves and society at large. Then alone, can the plight and the suffering of the girl child be taken care of and her rights safegaurded".

This is precisely the point we would like to highlight during this Conference.

2. For those of you interested in lthe field of Fertility and spacing child-birth by alternative methods, we have good news : news that this can be done in a natural way without drugs or devices. Among the current and pressing concerns of mankind, often so difficult and acute, are those concerning the regulation of birth, and they have become some of the contemporary society's confounding problems. They have driven man to search and research for answers and alternatives, that hopefully could solve the intricacies. One of the solutions and alternatives is the truly humanistic and wholistic method, the Natural Family Planning (NFP). I will not dwell on it, as you will be listening to the internationally acclaimed experts in this field during this conference. Perhaps so much of expertise in this area has not gathered under this roof, so far, at one time. We are fortunate to have them all with us during these three days.

3. Now for the other aspect of the theme; The Welfare of Women and the evils that plague the female child. "The birth of a girl grant elsewhere, here grant a son". These words found in Adarvaveda, show that the girl child was considered a lesser child and was, not-so-wanted a child, even centuries ago.

4. It is a good and praiseworthy thing that the member countries of SAARC have declared 1990 as the Year of the Girl child. The social and cultural problems of girl children are the same perhaps in all South Asian Countries.This declaration will provide an opportunity for these countries to study the conditions of girl children in their region and find solutions. Let us, during these three days, reflect and discuss how best we could give our 130 million Indian girls below the age of 20, and also girls of our neighbouring countries, a brighter future.

5. There cannot be health for all by 2000, unless the girl becomes a priority in health, nutrition and education policies, and receives her rightful share of food, schooling, health care and employment. The time is overdue for the girlchild to be given her share of human dignity and opportunity - not just to make her a better mother to the next generation, but simply because, that is her basic human right. There is no denying the fact that the girl is discriminated against, in all spheres of life, the root cause being the cultural practices and prejudices. About 42% of the Indian population comprises of children, and nearly half of those are girls. The opportunities they are given are not in proportion to their number. As Mrs.Indra Gandhi has said "Humanity is deprived of half of its energies and creativity if the women are neglected". Since indifference towards women and girls will adversely influence India's developmental goals, the nation cannot afford another decade of this indifference, which can create an alarming situation.

6. At the end of the United Nations "Decade for Women", the World Conference which met at Nairobi, while recording satisfactory advances, also remainded the world that a lot remains to be done for the integrated development of the female child. The SAARC Conference on Asian Children of 1987 recommended a major effort to educate parents and community to accept boys and girls as equals.

7. The integrated development of the female child should be everybody's concern, the family, the community, the Government and Voluntary Agencies, the Church and the media. The media which are such a powerful tool in bringing about attitudinal changes are indifferent towards issues related to girl children.

8. There is a traditional blessing that says 'May You be the Mother of a 100 Sons'. One of the SUTRAS prescribes the aim of existence of a women is to be the mother of sons, and the women who bears all daughters should be abandoned. The irony is the that the fathers are genetically responsible for the sex of the offsprings. If this information is disseminated, perhaps mothers would be blamed less for bearing female children. The gender based discrimination starts even before the birth of a girl child through amniocentesis and female foeticide. In a study of 8000 abortions after amniocentesis in a certain city, it was reported that 7999 aborted foetuses were female. We cannot treat the female foetuses as indiscriminate masses of sub-human expendables, as if they areunworthy to become daughters. The Irish Orator Edmund Burke's saying holds good here : 'An event is happening about which it is difficult to speak but about which it is impossible to remain silent'. All of us agree that the greatest gift of God is the gift of life and the greatest wrong would be to return it ungratefully and unopened.

9. If these females could follow the example of Draupadi of Mahabharata and assert themselves and ask 'Am I a person or property', it would be for their advantage.

10. As a member of the Islamic Studies Association, I happened to read an article on the Islamic code of Medical Ethics. Article VII of the code speaks on sanctity of life. It says: "Human Life is sacred and should not wilfully be taken. The sanctity of human life holds true to all stages, including those of the embryo and foetus". So the modern policies of permissive abortion are not sanctioned by Islam, nor by any other religion for that matter.

11. As we see in the life of Christ, His manner with women was open, trusting, respectful and nothing short of revoluionary, in a predominantly male-superior culture. He introduced a counter-

culture by associating women in his ministry and among his followers. He did it at a time when the existing cultural atmosphere was stifling and destructive for women. The courage of Jesus to be a non-conformist is something not merely to be admired, but it should be a pressing call not to accommodate ourselves with any social or religious culture which devalues the children of God on the basis of sex. During this conference, let us resolve to involve ourselves actively, whether in the field of changing the situation of the girl-child in general, or fighting against female foeticide, child labour and dowry problems, or helping women to space child-birth b creating fertility awareness among them. Let us do it with strong motivation and dedication so that the outcome of ou endeavour may be healthy, active, confident, 21st century female children and women not merely playing a recipient rol but an active productive role. Receptivity is no longer specifically feminine and creativity is no longer specifically masculine, but both receptivity and creativity are dynamically connected in the human person's response to Go

HER NAME IS TODAY

"We are guilty of many errors and many faults,
but our worst crime is abandoning the children,
neglecting the fountain of life. Many of the
things we need can wait. the child cannot. Right
now is the time her bones are being formed, her
blood is being made and her senses are being
developed. To her we cannot answer "Tomorrow".
Her name is TODAY"

- Gabriiela Mistrala
(Chilean Poet)

KEYNOTE ADDRESS ON "THE YEAR OF THE GIRL CHILD"

Mrs. Meera Saksena, I.A.S.,
Director, Welfare of Women and Children, Bangalore, India

1. The Women in India constitute about 50%of its population, and yet we find that they are occupying a less privileged role in society, and are made to suffer grave injustuces and inequalities. it is a recognised fact that women constitute a third of the organised sector, and perform the most ardous and time consuming tasks at home, and yet the fruits of development have not reached them as envisaged. In India, social customs and traditions have greatly restricted women's mobility and their participation in various development programmes. The girl child starts with a number of handicaps which keep her in subordinate position throughout her life. In a culture where boys are prefered, the girl child is frequently regarded as a burden on the family, whom her parents seek to get rid of as early as possible by marrying her off. This is the main reason behind the obnoxious practice of child marriage. We have a great many examples of children becoming widows at a very early age, and are forced thereafter to lead a life of self denial for no fault of theirs.Though there is a legislation in India against child marriage, the practice has not yet been rooted out.

2. Education is not considered necessary or desirable for girl children. as they are expected to play second fiddle to men at home. Education at the primary and secondary level is provided free in this country, yet girls are placed in the unfortunate position of not being able to avail of this facility. Although it has been established by experience that not infrequently, girls gave a better account of themselves than boys in schools and colleges, when they do go here their drop out rates are higher than those of the boys. This is because girl children are required at home to assist their parents in household chores such as cooking and cleaning,looking after younger children,for which education is not considered necessary. The girl child gets the least nutritious food in the family as a person of little consequence, while her more fortunate brothers receive the lion's share of the food. Consequently, she suffers from malnutrition and related diseases.

3. The prevalence of dowry system is a heavy burden on parents, which does not end with the marriage of the daughters.They are tortured for bringing inadequate dowry, and sometimes commit suicide, while in their teens unable to bear the torture. Some are killed by their husbands and in-laws. Though there is a legislation in India against demand for dowry, it lacks strict and wide implementation.

4. Girls in India face other forms of discrimination and exploitation. They are sold by needy parents to lead a life of ignominy in brothels. By resort to the practice of Devadasi dedication, as in Northern Karnataka. Free education should be made available to girls, especially in tribal areas. The technical training facilities should be enhanced, and scholarships should be given. Rural based training programmes should be started. 75%of the girl children in India work in industries,but safety measures and schooling are not provided for them. Employers escape the obligations imposed by factory legislation.

5. Medical examination for all school children, at least at the primary level should be made compulsory. The example of Kerala where all school children have been insured against sickness,accident and death,should be followed by other states. Health services should be improved. Information about the services must be made widely available. Public health programmes should include evironmental sanitation, supply of portable water,building of latrines,maternity benifits,and instructions in family planning. Besides this, to promote the survival, growth and the safety of the female child, immunization should be ensured. Social awareness campaign should be undertaken.

6. Wherever the female sex ratio is low, a special investigation should be carried out, and remedial measures such as curbing female infanticide should be adopted. Preferential allotment of bank loans for income-generating projects for couples who have more than one female child could be introduced. Community kitchens could be set up, which will provide employment and training in the running of kitchens to a large number of women.

7. Vocational training and formal and informal education will lead to economic independence which holds the key for women's development into responsible and useful members of the society.

8. SAARC has declared 1990 as "The year of the girl child" to focus attention on this much neglected section of society, which is expected to contribute to the productive and reproductive processes of a world in which the contribution of women and its importance in the overall scheme has so far largely remained unrecognised.

GANDHIJI'S VISION FOR WOMEN

Dr. Illaben Naik, Assistant Director, Population Education Research Centre, Gujarat Vidyapith, Ahmedbad

1. To understand Gandhiji's approach to the question of women's development, we must consider the evolution of his own personality and philosophy. Secondly, it is also necessary to consider how he interacted with women who came in contact with him in his personal and public life. Finally, we should also recall his own pronouncements on various occasions when he was called upon to reflect on this question. It has to be noted at the outset that he accorded a central place to this question, in social transformation, which, according to him, was absolutely essential if the country had to make any worthwhile progress.

I

2. Born in a middle class family in the service of a native state, Gandhiji was, in his childhood, quite an ordinary boy who enjoyed the opportunity to pursue his studies as best as he could. But the factors which set him on a path which led him to ultimately become a leader of humanity were :

   (1) The universal values of India's ancient culture, he could imbibe from his mother, to whom he was devoted beyond any doubt or reservation. In fact, the ideal of womanhood which his mother represented for him, got strongly entrenched in his mind for all time to come.

   (2) His unshakable resolve to follow any vow that he took.

   In this regard, he had displayed an extraordinary courage of conviction, and a spirit of fearlessness, which served him well in his own progress, both in personal and in public life. From early childhood, he had cultivated a distaste for falsehood or irrational customs, traditions and superstitions. His childhood prepared him to pursue life as an experiment in truth and non-violence, and to apply this approach to all problems he faced in living a life entirely experimental in nature.

3. In a sense, he came to accept his mother as a model of purity, renunciation, love and suffering. It is this model that had always guided him in his interactions with women throughout his life.

4. The second woman who influenced him was obviously his wife, Kasturba. They were married quite early. An adolescent Gandhi was enamoured of his wife, and he candidly confessed to having treated her, in the first few years, as an object of his carnal desires. Kasturba was strong of character, but she was brought up in the Hindu tradition of submission to her husband. In the course of their married life, Gandhiji and Kasturba grew up together to flower into an ideal Hindu couple. With the passage of time, she did have occasions to assert herself, and even dispute what her husband commanded. Even so, she came to realise, quite early, that her husband proved to be right in all such cases, and therefore, she submitted to be his alter ego and made it her mission to serve society through the service she could render to him.

5. But it is obvious that Gandhiji too had a lot to learn from Kasturba. In fact, in his life's mission, Kasturba's contribution to its success must be given its due weight, which is quite considerable. Without her abiding faith in him, and without the strength of her character, Gandhiji would not have been able to lead a life of continence while leading a wedded life. It was his decision to observe continence at the early age of 30 years, and to take a vow of "Brahamacharya" at the age of 36. It is during this period of pure co-sharing of life that Gandhiji came to value

the healthy association between the two spouses. As a result, their mutual love and respect were progressively enriched. In several instances, Gandhiji would not take a step without consulting Kasturba. Not only that; he was well aware that she had the right to take him to task if he became unduly intrusive in her life.

6. In conclusion, it can be said that Gandhiji had come to worship womanhood in the model represented by his mother, and to concede equality to women after seeing within his own family, how a woman could attain the pinnacle of spirituality while leading a life of a housewife.

II

7. A votary of truth and non-violence cannot countenance inequality on any basis whatever, and this is equally true of the division of humanity into two sexes. Gandhiji, therefore, learnt to practise equality of men and women in his public life too. In fact, in his fashioning the instruments of the freedom struggle, he realised that the struggle had remained weak because it had excluded women for a long time. He had realised that the practice of truth and non-violence came naturally to women. The surest way, therefore, was to draw women of all classes into the mainstream of the freedom struggle. He unequivocally asserted that freedom cannot be won without full and equal participation of women. He, therefore, called upon women of this country to discard the "purdah" and take up the tasks of social reconstruction without which true freedom could not be won.

8. It is recognized by all that he was able to galvanise womanpower for the freedom struggle on a fantastic scale. In doing so, he generated consciousness among women of their identity, and an urge for fearless fight against their relentless exploitation for centuries.

9. In accomplishing this task, Gandhiji had invited many women of outstanding abilities to join him in the struggle for freedom and social transformation. His influence on the women of the Nehru family is a notable instance - Swaroop Rani, Kamaladevi and Indira Priyadarshani were greatly influenced by him, and by his preaching of equality of the sexes. Both Swaroop Rani and Kamaladevi came out of their cloistered hearth to actively participate in satyagraha and to court jail. Indira organised a "Vanarsena", and blossomed into a politician who could occupy prime ministership for as long as 17 years. While as a politician she cannot be said to have followed Gandhiji in his essential teaching, it cannot also be said that the imprint of Gandhiji is, totally absent from many things that she tried to do for this country. If she could acquire this high national status that she did, it is due to the fact that Gandhiji's influence had permeated the Nehru household so much as to erase the difference between a daughter and a son from the minds of males of that family.

10. The number of eminent women who participated in Gandhiji's work on equal terms with men is indeed very large. He had succeeded in moulding many of these women into national leaders who could participate in deliberations on the nation's destiny in the assembly of men.

11. Among his political co-workers, we have Sarojini Naidu, a westernised rebel of "great academic distinction, a poet, a writer and an orator" From the beginning, Gandhiji saw a great potential in her personality, which could mature her into a pre-eminent national leader. They both cultivated each other's friendship, and always helped each other in their common endeavour for freedom. His regard for her was so great that she was named to lead the salt satyagraha, after he and his immediate successor, Tyabji, were arrested. As his fearless

and unflinching follower, she led batches after batches of satyagrahis at Dharasana in Gujarat. She was also made the president of the Indian National Congress, and she adorned that chair with distinction unmatched by her male predecessors or successors. Gandhiji was often led to place a greater store on the patience, perseverance and capacity for suffering and sacrifice that women naturally displayed in contrast to the im patience and recklessness that the men often showed. That is why he always pleaded for granting to women their right to equality in the public and political life of the country.

12. Among the constructive workers we had a westerner who gave up a life of prosperity and high social status to join him in India as his co-worker. she was named Miraben, who became a symbol of the constructive work of his liking in his Ashram.

13. Gandhiji respected Miraben's devotion to constructive work and left her free to choose the type of activity she wished to undertake.This was true of all Ashram inmates; in the Ashram no distinctions between men and women, boys and girls were recognised. While, on her part, she had come to be a devoteeof Gandhiji, he did not accept that position and invited her to be his co-worker and to exercise her freedom to pursue her life's mission in her own way. He only gave her advice whenever she asked for it. This relationship of mutual respect lasted all through his life, and Miraben continued to follow till her death that part of his mission which she had chosen.

III

14. Gandhiji recognised that the same soul resides in both male and female bodies. There was thus no basis for an inequality, inequity, or discrimination between the two. He, however, recognised that nature has imposed a biological differentation, functional in character. This differentation in fact makes women superior to men in several aspects. He had the occassion to express these ideas in several differing contexts, which we will briefly quote below:

> "To call women the weaker sex is a libel; it is man's injustice to woman. If by strength is meant brute strength, then indeed is the woman less of a brute than man. If by strength is meant moral power, then woman is immeasurably man's superior."
>
> ". . . I am uncompromising in the matter of women's rights. In my opinion she should labour under no legal disability not suffered by man. I should treat the daughters and sons on a footing of perfect equality.
>
> "I would rather see the race of man extinct than that we should become less than beasts by making the noblest of God's creation only the object of our lust.

15. Gandhiji recognised that biological differentation was the nature's requirement for the propagation of the species and love is the attribute of the nature of all human beings. Love between man and woman is no different and should always inform all aspects of their living. The love between spouses is not of any special kind except perhaps it is invoked for the purpose of procreation. In this regard, he never believes physical attraction as the basis for sexual indulgence. His ideal, for which he could find support from our ancient culture, that sex without the intention of procreation is sin. He said, "My ideal is to make husbands and wives to practice total celibacy. If that is not possible, my purpose was to say that both should, within limits, participate in the function of procreation. That is to say, sexual union between the two should be permitted only for the sake of this function, and that too for the limited number of children they both desire."

POPULATION CONTROL

Dr.P.B. Desai, Visiting Professor, Gujarat Vidyapith, Ahmedabad, India

1. The observance of the "Year of the Girl Child" has been delayed by more than four decades. What would have been the position today if we had designated the first full of independence, 1948,as the year of the girl child as the symbol of shedding all superstitions that our long cultural history has attached to a purely functional differentiation designed by nature for the vital process of the perpetuation of our species? If we had done so, and followed it up with steps of educating people in the replacement of love for lust of which the fair sex had remained a victim for millennium, we would have imparted meaning to the freedom we had obtained in 1947. For one thing, we would not have had the misfortune to suffer the consequences of our hapless striving to contain population growth.

2. The situation in this regard has become desperate, and we are now called upon to help to deal with it through what has been called "Population Education". Why qualify "education" by any such objective? Education is indeed that process which frees the mind. True education would enable man to appreciate the imperative of tempering his procreation in the light of economic and social compulsions of the society in which he must live. Ignorance,indolence,illiteracy and superstitions.have remained pervasive. People see no light, and even when social action has reduced mortality, they see no option to excessive procreation. In the dreariness of their life, they seek elusive joy in early wedlock, and indulgence within it that leads to excessive progeny. They do not realise that they themselves can, through rational behaviour, escape avoidable death and dis ease, nor do they realise that their misery can be alleviated through wholesome restraint on procreation.

3. That is what has made it necessary to undertake their task of educating, informing,instructing and persuading the people to refashion their styles of living, so that they suit the prevailing evolving situation of overabundant humanity. We need to qualify education by a host of objectives,because,basically,we still carry on the colonial type of educational system which creates dependence rather than freedom for the beneficiaries. Fortunately, the beneficiaries are few,and they have, under the changed circumstances, become addicted to a fertility-de-pressing western consumerism. We will let them alone in our effort of "Population Education".

4. Our concern is partly about those still in school, and principally, with the multitude of those outside,be they young, adolescents, or adults in the prime of their reproductive span, as well as those, who, irrespective of age, are exposed to undue risks of death and disease. We must reach them through out-of-school,adult, informal, non-formal and continuing education. That can only happen if we make them participants in this stupendous venture of acquiring knowledge, information, skills, values and world-views.

5. Population education, though born illegitimately of the failure of family planning programmes mounted by the elite, can be made to serve a positive purpose which is to generate understanding among the people about the dynamics of popu-lation change. that change today is one of the excessive rapidity with which the aggregate of human beings is expanding.People must be made to understand that the aggregate change is but a manifestation of the multitude

of events - births, deaths and migrations - which directly affect them, often adversely. They must realise how population growth and its off-shoots, urbanisation and metro-politisation, undermine their economic and social options and damage their environment. Unless they, therefore, modify their behaviour patterns, they individually, their families, their community, and their national society will suffer, and there will remain no hope for progress of any kind. It is an education that enables them to enjoy freedom of choice that they must exercise with due sense of social responsibility; an education that ennobles the soul, and lifts the spirit from egocentricity to focus on universal love and service.

6. Viewed in this wholistic manner, population education exhausts the scope of all or any kind of education. Its ultimate purpose is to reach human beings how to live with humanism. But today it must focus on certain issues of the times. The most basic among them, claiming overriding priority, is to restore to the fair sex their birth right to freedom from economic exploitation and social subjugation. This means that we afford them the fullest possible opportunities to develop their potentialities; to guide them not merely to be on par with, but also to surpass, the biologically weaker but socially dominating male human species. Population Education must be designed to squash the sense of surveillance, and the fear complex that inheres the female psyche, so that they may refuse to surrender the command over their persons to males, and simultaneously to lift off the male conscience,the load of moral discord generated by the very excesses he is accustomed to impose on the female. The so-called son preference is, for example, a superstition that damages social relations and must be eliminated entirely.

7. Can population education do this? The question remains and must attract the intelligence and imagination at the command of those who may pretend to impart it. At long last, we have started of speaking of women's development, which should have been the first step in mounting a war on excessive levels of morbidity, mortality and fertility.

8. Population education so devoted to the cause of universalising human freedom must deal with several specific issues.The two most important of them relate to infant and maternal mortality, and the female age at marriage. Infant and maternal mortality rates in our country are among the highest in the world. They differ from state to state within the country. They are low where women are educated, informed and employed. Often the ex ample of Kerala is cited to prove this point. But there the medical and health services respond to the demands of women who are conscious of their rights. They are perhaps better educated in a general way but there is more to it than that; the general social atmosphere on the whole is favourable. Therefore, it becomes the primary task of population education to inform men and women all over the country of the causes of these high mortality rates, and about how these causes can be removed by their own effort which must necessarily receive logistic and infrastructural support from the government medical and public health establishment. Population education is, in this regard, a catalyst for a countrywide social action. The reduction in infant and maternal deaths merits priority attention on its own, even though it is well recognised that it is vital for the initiation of fertility decline as well.

9. About female age of marriage, we have not made any serious attempt to raise it. The Sharada Act and the more recently legislation on the subject have miserably failed. Even the law-makers often break this law. The age is rising, but much too slowly. Newer social forces are helpful in this direction, but the

entrenched habits of thought, fed by age old customs and traditions, are much to strong. This matter poses a challenge for population education. The mass media is doing its best or the worst in this regard, without any positive or negative effect. It is all right to inform parents of the health hazards of premature motherhood, but in a social milieu in which women are held to be expendable,such preachings do not help. We must innovate and address ourselves to the youth, the prospective grooms, who may be persuaded to shun wedlock till they, on their own, become capable of maintaining a wife and a family. In any case, persuasion to delay marriage occupies an important place on the agenda of population education.

10. These are but two elements of population change that deserve special attention. The traditional concern with family planning remains. In this regard, undue emphasis on such things as sex-education, contraceptive methods, interspouse interaction and population control is unwarranted. Family planning is a whole some all inclusive concept which has lost its main thrust on becoming a matter of government dispensation. Family planning, ideally, is an instrument of restoring to the woman her freedom of choice in the matter of jointly taken reproductive decisions; it initially formed a part of the emancipation of women from ruthless exercise of male hegemony and a means to reduce the risks to their health.

11. However, what has made population education imperative and rendered its task much broader and more challenging, is our acceptance of the goal set by the Alma Ata Declaration for this year 2000; health for all to be attained through primary health care, inclusive of family planning. The conceptualisation of this primary health care is catchy; it is propounded to achieve universal realisation of "positive health" through decentralisation of services in the planning and running, in which people must fully participate. People's participation, decentralisation and cost-effectiveness are slogans that must be transformed into realities if we desire to achieve a semblance of positive health for all by the year 2000. In this regard we should recall the Alma Ata definition of positive health which is "a state of complete physical,mental and social well-being and not merely an absence of disease or infirmity". I would hazard the contention that none in this august, learned and well-informed body can claim to enjoy this state of positive health.

12. In the conclusion, Population Education is a wholistic people's movement which must succeed for the benefit of the dumb millions multiplying at a rapid rate. The medical profession has a vital role to play in generating and carrying forward this movement. But, for the medical professionals, the opportunity costs in material terms are tremendous. Let people have the benefit of medical expertise as a part of population education that must, at the same time, deal with political,social,economic and environmental aspects of people's health.

DIGNITY OF WOMEN : AN ETHICAL CONCERN

Dr. Thomas Kalam, CMI, Associate Professor, Bio-medical Ethics, St. John's Medical College, Bangalore, India

1. At the heart of any ethical discussion is concern for human dignity. Human dignity is a contradiction in terms, if it is restricted to some type of human beings. Wherever there is discrimination against human beings, on the basis of caste, creed, colour of the skin, or sex there is no belief in human dignity. Dignity in such discriminatory situations seems to be based on other superficial factors, like race, caste and so on. If concern for the dignity of women as human beings is absent in any discussion, such discussions cannot be described as ethical. They are unethical, and are expressions of a heartless male dominated world.

2. In the areas of fertility, procreation, sex, etc. often an impression is created that ethical discussions fail to pay sufficient attention to the plight of women. For example, in discussing the issue of abortion, very often people argue vehemently for the unborn life, at the same time refusing to pay any attention to the plight of the woman who is bearing the unborn life in her womb. Last November, I was standing in front of a Boston Church watching "Pro-Life" people (a movement which opposes abortions in USA) distributing pamphlets condemning abortions. A young lady approached me and told me: "These people seem to have a lot of respect for human life from the moment of conception till birth." The implication was that they do not seem to have any concern for life once it is born.

3. In this paper, an attempt is made to explain how concern for women and their dignity forms, or should form, part of any ethical discussion. Where this concern is absent, ethics can become a tool in the hands of some vested interests, in manipulating the defenceless people (here women) for the sake of a *status quo.*

Pro-Life : Unborn and Born Alike

4. It is true that respect for life obliges one to oppose direct abortions. There exist volumes of written material to prove why abortions are inhuman, unethical and an expression of selfish and self-centred egotism of today. As Mother Teresa says any nation which has to kill its unborn citizens is the poorest in the world. Paradoxically it is the materially poor nations of this world. This concern for the unborn is truly ethical as respect for human life and its dignity is at the heart of this position. The ethical problem here is when people who are conscious of the dignity of the unborn life become oblivious to the plight of the "born life" in such situations. What about the other life involved in this question: that of the mother.[2]. Let us take the case of an unmarried girl who is pregnant as a result of rape or incest. It is a blatant escapism in ethical discussions to refuse to consider these cases on the pretext that no girl ever conceives as a result of rape, or that such cases are rather rare. On the Indian scene, at least, pregnancies as a result of incest are not very rare. By telling the girl concerned that the foetus which grows in her womb is a human being, and therefore, it should not be destroyed, concern for only one of the lives involved is shown. What about the life of the girl who is pregnant and unmarried, especially in the Indian context ? Is she not innocent too, especially if this pregnancy was thrust on her against her consent ? Would any man in our society ever show the courage of marrying her, even if it is proved that she was the innocent in

the whole affair ? What will be her future ? All the tears that the so-called "pro-life" people shed for the unborn life in this case are "crocodile tears" in the absence of real concern for the well-being of the pregnant girl. What viable alternatives do we have to propose to this girl ? Abortion is out of question, because of our respect for all life. Good. Therefore, should she be advised to go ahead and have the baby and hope for the best in life in our society ? What about her reputation ? Would even the man who raped her, volunteer to marry her if she is willing ? Have we made arrangements for her to have the baby in a way she can protect her reputation as well ? In the absence of such viable alternatives, who has got the right to moralize in this situation to this girl ? May be, people like Mother Teresa of Calcutta have the right to speak against abortions, because she is courageous enough to offer all help to the girl in question. A Catholic bishop in England once issued a statement saying that if there was any woman who found it difficult to bring a pregnancy to term because of financial problems, he was ready to place all the wealth of his diocese at her disposal in order to help her to have her baby. People like this bishop have every right to speak to this pregnant girl not to destroy her unborn child. Respect for life must be integral. Unilateral respect for the unborn life, and callous disregard for the plight of the already born life, is a hypocrisy. In some countries like U.S.A. the conservative right wing, who are against abortions, at times have no qualms whatsoever in encouraging all sorts of military and financial assistance for the right wing regimes in South America, and other places who use such assistance to liquidate the poor and their champions who clamour for justice and fundamental rights. Their respect for life seems to end the moment the life is born into this world ! ! Especially in societies like ours, all discussions about the sanctity of the unborn life should take place in the context of the predicament in which an unmarried mother finds herself in this society. If we are honest about our convictions about the value of the unborn life, how can we discriminate so cruelly against those valiant, but unfortunate unmarried women, who show the courage to have their babies, and not abort them ?

Pro-Choice : Backfiring !

5. There is another side to the question of abortions : any ethical reservation regarding abortions is considered by many women as an outrageous encroachment into the rights of women over her own body and life. On the 28th of December, on the feast of the Holy Innocents, the babies whom Herod had murdered in order to get rid of the new born Saviour, there is a new custom of tolling the bells in Catholic Churches in West Germany for the modern "holy innocents" who are killed through abortions. One thing is certain : the "Pro-choice" (right of women to choose to decide what to do with her pregnancy) movement considers the unborn as part of the woman's body, an extension of her life, about which she has all the right to make a decision. Evidently this is an unwarranted stand point. The foetus is not like another part of a woman's body. It has a different genetic composition and a different destiny than that of the mother. Therefore, arguments in favour of the right of the unborn to exist, need not be considered in themselves as lack of concern for women's well-being or dignity.

6. The arguments in favour of pro-choice for women are backfiring on women themselves at least in some developing countries like India : the female foeticide. What are the arguments the women's rights movements are going to level against the wide spread practice of getting rid of the female foetus in these countries ? If women have unrestricted right to decide whether or not the unborn should live or die, the fact that the unborn is a female child, does not add any additional reason to say that

it should be destroyed. Therefore, the "pro-choice", "pro-abortion" movement will have no other choice but to keep silent when widespread female foeticide does mar the very dignity of womanhood itself. In a study conducted in Bombay it was found that out of 7000 foeticides, 6999 were of female foetuses.

NFP : Protection against Masculinization of Sexuality

7. Another area of ethical discussion where at times women feel that their rights are not given enough consideration is that of family planning. Here too concern for the equality of woman with man is at the core of all these ethical discussions on the correct method of family planning. It is an accepted fact that human beings have to be responsible for the number of the children they beget. No sensible person would say these days that they are supposed to increase and multiply like rabbits. After all when the commandment to increase and multiply was given to the first couple in the Bible the population of the world was just two ! The question here is how to limit the number of children. There are two basic methods : the so-called "natural" and the so-called "artificial". Why is the natural method considered ethical and the artificial unethical ? Many reasons are proposed. The natural way is the way designed by God, and therefore, there should not be any interference with that process. This argument does not hold water in the light of the fact that "nature" when applied to human beings includes also reason and freedom which are natural to them. Just the biology of the sexual act cannot be considered as of "divine design" without any reference to human reason and freedom. The question one can ask to the proponents of this argument of "biologism" is : From the fact that the biology of the sexual act is not interfered with, can one conclude that that act is natural and human ? Even in rape the biology of the sexual act can be intact. That does not make it "natural" or human. Again, it is an accepted fact in day to day living, when nature does not function properly, artificial interventions are not only permissible, they even become obligatory in many cases. Any intervention that perfects nature is considered ethical. Therefore natural family planning methods cannot be considered more ethical simply because it is not interfering with the biology of the sexual act.

8. The reason for the ethical superiority of the natural methods over the artificial must be sought, in my opinion, in the question as to which method is more human, more conducive to the well-being of both the husband and wife as equal partners in marriage. It is not enough for human beings just to procreate children in any way, but in a way that is conducive for their well being, fulfilment and personal growth. The institution of marriage and all the ethical codes that have been accepted by the civilized world are based on this presupposition. In the same way, it must be said that it is not enough for the human couples to limit the number of children they beget in any way, but in a way that is conducive to their own fulfilment, personal dignity and so on. The question here is : which of the two methods is in itself more conducive to this aim ?

9. There is a widespread misunderstanding in today's world according to which any sexual act is automatically satisfying to human beings. All that is necessary for sexual satisfaction, according to this thinking, is a man's ability to establish sexual relations with a woman. I once read in an American tabloid a write-up eulogizing the advantages of rape :

> "Now as all women know from their daydreams, rape has a lot of advantages. Best of all, it's so simple. No preparation necessary, no planning ahead of time, no wondering if you should or shouldn't : just whang ! Bang !"

Thanks to the researches of Masters and Johnson, and the insights provided by post-Freudian ego-psychologists, even the scientific world today recognizes the fact that, for the female "hang ! bang ! can scarcely be described as pleasurable, or bringing sexual satisfaction. It is one of the canons of sexology that any sexual act that takes place outside the context of love, affectivity and mutual respect, is going to be aversive to human beings. The ancient Roman philosophers said : *"Omne Bestum post coitum triste"* (every animal is unhappy after coitus). This is clear in the animal world. All the excitement and attraction ends with coitus. For human couples, however, who cherish each other in their hearts, who care for each other, even when the bodies are not attracted to each other after coitus, there is a stronger bond to unite them to each other in love, gratitude and mutual respect. In the absence of this bond, every sexual act ends up in disillusionment and disappointment. The essential ingredient for the sexual satisfaction is the presence of real affectivity in the hearts of the partners for each other.

10. Now the question is : which of the methods of family planning encourages this mutual love and respect between the partners in marriage ? Surely, mutual love and respect do not depend on any method. But the method can be a factor in promoting or destroying them. When Pope Paul VI banned the use of artificial methods of family planning for the Catholics, one of his reasons for doing it was the damage that artificial family planning mentality can do to the lives of the married people. This mentality is expressed in the attitude of one partner demanding from the other : "Be available to me sexually without the consequence of procreation whenever I need you. If you are not available so, I will either distort the act of intercourse (behavioural methods of family planning), put barriers between us (mechanical methods), interfere with your biochemistry (chemical methods) or mutilate you (surgical methods)". This is not the language of love. The sexual act, as John Paul II says, is supposed to be a language of love. Such a language cannot be the expression of the unilateral decision of one of the partners. It must be the expression of the total and unconditional surrender of the couples to each other. Artificial family planning methods can promote a mechanical attitude towards sexual life. The marital infidelity and suspicion that are predominant among the people who are addicted to the use of the artificial methods seems to be a proof that artificial methods tend to make marital life too mechanical and impersonal.

11. It is usually the woman who has to take all the risks involved in the practice of artificial family planning. Though vasectomy is an easier process than tubectomy, men want their wives to go for sterilization rather than volunteering themselves for it ! The harmful side effects that the chemical methods involve is very often of no concern for the man.

12. The natural family planning method, on the other hand, is conducive to promoting an atmosphere of deep communication between the husband and the wife, without which this method is not going to be successful. The sexual act can never become mechanical here, as intense and deep-level communication is essential for the success of the method. Concern and love for the partner is the hallmark of this method, and not lust and the urge to reduce the sexual tension. Abstinence from sexual act at least for a few days is built into this method. Such self-control is proved to be not only essential to any loving interaction between human beings, but also one of the best aphrodisiacs for a healthy sexual life (Cfr. Germaine Greer, The Politics of Human Fertility Chapter 4 : "Chastity is a form of birth control"). Some people maintain that artificial means are the only practical method of practising family planning, because it does not involve any need for abstinence or self-control. Is not self-

control part and parcel of any genuine love.[2] What would happen to a man who has never learned the art of self-control for the sake of love. when his wife is ill or indisposed ? Go after other women ? That was the fear which Paul VI expressed in his *Humanae Vitae.*

13. It is often said that for the poor Indian villager, the sexual life is the only entertainment and recreation in his life. The question we should ask here is : Who is this villager ? A man or a woman? It seems in our villages only the men have a right to their sexual life and enjoyment. Who asks the question whether his wife too is enjoying this act which is often inflicted on her by a drunken, unconscious or semi-conscious husband, unmindful of the emotional or physical needs of his wife. Sexuality has become masculinized : it is considered as an exclusive domain of the man; women are considered to be just tools for man's enjoyment. That is perhaps why people do not want to use the beautiful word "intercourse" to refer to the sexual act between the husband and wife. All the slang four letter words that are used to refer to this act today are all masculine words : what a man does to a woman. Women seem to have no role to play here. It is surprising to see even the so-called liberated women using these "masculinized" distorted terms to refer to the sacred relationship that is expressed by the sexual act between a man and a woman. Artificial family planning methods seem to be promoting this masculinization process of sexuality.

14. These two examples of the issues of abortion and contraception were used here to illustrate how the dignity of all human beings, men and women alike, is, or should form the core of all ethical principles that guide our actions.

" Sex education is like vaccination - a protection against the harmful media in the environment".

CARING FOR THE GIRL CHILD

Padma Bhushan Prof. Dr. P. Tirumala Rao, Professor of ,Gandhi Medical College and Hospital, Hyderabad, India

Introduction

1. This is the year of the girl child. The world over, we are planning to promote child care by various approaches and build up a happy generation, treating the entire world as one through various national and international organisations. The United Nations have been allotting a particular year to each of various segments of humanity in order to focus the attention during that year to a particular segment. According to this scheme, we have celebrated, and are implementing projects for the women's decade, and the handicapped child, by promoting positive efforts of health care in the world. While we are concentrating on these positive aspects, we are, this year, observing, "The year of the girl child", to highlight the tragic circumstances in which a girl child has to survive, both in the civilised and the uncivilised sections of humanity. It is a strange phenomenon that humanity should have developed, in both these sections, similar attitudes towards a male child and a female child. This is an irony of our civilisation. The subject is most important for the developing nations, since children generally in these nations, and girl children, in particular, survive in very trying circumstances.

Predilection for a male child

2. The United Nations and its active limbs, the WHO, UNICEF etc., are planning many health measures - preventive and curative - to build a better generation. Where in accostancy with these plans, there was strict control of population, the first choice in a family is a boy as they feel that the family's future prosperity depends upon the male child.

Why preference for a male child ?

3. (i) The male is the biologically dominant gene.
   (ii) Traditional belief all over the world that the husband is th protector of the family and lineage.
   (iii) Only men and not women can wage a war, when necessary

   While these are all positive reasons for the desire of a male child. the girl child also has her own role to play. She can als grow to full biological strength providing many complementar aspects of life.

Why this prejudice against a girl ?

4. Age-old prejudices make the parents feel a girl is a liability sinc she goes to her husband's family after marriage. Investment o a girl gives no return to the investor, that is the parents. Although traditionally, especially in a Hindu society, a girl emo tionally represents the "Goddess Lakshmi", that is, "the God- dess of Wealth", the first choice is for a boy.

Is science a boon or a curse ?

5. The recent scientific achievement to detect sex before birth ha created problems. This was expected to be employed for detection of the handicapped and other defective children, an to abort them to avoid a social burden. The invention is bein misused to abort female children.

(i) Bombay experiment

In an enlightened city like Bombay, with a wide network of health care, where abortion is legal, a study revealed, that out of 8000 abortions that were carried out, 7999 were due to the detection of girl foetuses - note, not with any handicaps !

(ii) Chinese experiment

All were happy when China declared that they were permitting only one childbirth in a family. This was intended to secure a strict control over the population explosion. But despite communist philosophy which makes no distinction between the sexes, Chinese families also prefer a male child. Since it is only one child that they can produce and possess legally, frequent intra-uterine determination of sex resulted in secret abortions whenever it is female.

Thus science has become a curse due to perverted application, both in developing and developed human society. In some rural parts, newborn female infants have been killed by putting some poisonous oils into their throats

Some improvement in the present situation

6. In all the SAARC countries, and especially in India, many rights have been conferred on women. The Gandhian movement during our freedom struggle has helped to a great extent to prevent discrimination against women. May women took part in the national struggle which contributed in developing, over a period of 40 years, a better attitude towards, and amelioration of, girl children.

7. Education as a remedy

TABLE I

Percentage of children attending school in major states 1981

India/State	Age group (in years) 5 to 9			10 to 14		
	Total	Boys	Girls	Total	Boys	Girls
India	38.45	44.33	32.21	50.45	62.07	37.47
Andhra Pradesh	40.51	47.04	33.88	41.12	51.64	29.78
Karnataka	43.25	48.71	37.78	48.07	58.14	37.80
Kerala	75.10	75.14	75.06	85.96	87.90	83.97

This table shows, for the year 1981, the percentage of education of boys and girls educated in India as a whole, and a few representative Indian States. The wide disparity (except in Kerala) between boys and girls the attendance in schools is apparent, which is an indication of the social attitude towards girls. In Kerala this disparity does not exist. This is because, in Kerala where the society is matriarchal, women are not regarded as a social handicap.

TABLE II

Sex Ratio in states of India (Females to 1000 males)

Sl.No.	India/State	Total	Rural	Urban
1	India	933	951	878
2.	Andhra Pradesh	975	984	948
3.	Kerala	1032	1034	1021

In spite of their handicaps, the survival ratio of females in the country as a whole is practically equal to that of males. Here again, in Kerala, with its matriarchal society, the number of females exceeds that of males. Though the difference is minimal, it indicates better care for women in the Kerala environment.

Handicaps all over the world

8. Generally speaking, women all over the world suffer from emotional trauma. Even in the developed western society, women have to fight for their rights through "suffragette" and such other movements. There were times when, even the words 'family planning' and 'abortions'could not be uttered. In a cinema of Hollywood, a woman in the bathing suit created a convulsion. In Boston, in the early part of the century, women were respected only when they wore Victorian gowns which covered their entire bodies. I came across an American professor who had produced a son after the arrival of six daughters. Coming as I did from India where so much of family planning is talked about, it surprised me to find a professor with as many as six successive daughters and at last one Bob ! That shows how deep is the desire of the families, even in the most advanced countries, to have a son whatever may be the reason. Thus the love for a Bob is universal.

Some traditional savings

9. The following are Sanskrit sayings -

   (i) "Aputrasya Gatirnasti" (no salvation without a male child).
   (ii) "Bringing up a daughter is like watering a plant in another's courtyard".
   (iii "The birth of a girl - grant it elsewhere; here grant a son".

Some of these sayings indicate this traditional and universa deep-rooted emotional negative attitude towards female children.

Conclusion

10. Remedies against anti-female prejudice, such as mass educa tion, improvement in literacy, better environmental and economic resources to help families in a general way, are needed to bring about the necessary social enlightenment which would effectively remove the present-day handicaps under which a girl-child suffers, particularly in the developing countries where intrauterine infanticide is widely practised.

SONG OF THANKS

My dear Girl Child, born and unborn;
Before this agust assembly, I unfurl, to adorn
The flag of your glory, of the present and future,
For the whore humanity, eternally to salute and nurture
Thank you Sisters, Fathers and Sr.Agostina of St.John's Medical College
For serving the nation through this
Conference - a 'Fertile' beverage !

by ***Padma Bushan Prof.Dr.P. Tirumala Rao***

THE WELLNESS APPROACH TO MOTHER AND CHILD

Dr. Mary Shivananda,Director, K.M.Associates, Maryland, U.S.A.

There are two aspects to "Wellness Approach" - one is the Disease that the doctor treats and Prevention which the patient hopefully does himself. In the "Wellness Approach", the emphasis is on prevention rather than on cure, as emphasised in the Alma Ata Declaration. The modern "Wellness Approach" movement is the product of 1970, and the idea of "Self-care classes" is a recent one. Levels of prevention are Primary, Secondary and Tertiary, which in turn lead to the well-being of the person. The level of wellness should be improved without waiting for symptoms.

2. In the primary stage, to initiate the positive state of health; health education classes have to be undertaken. Health education should be promoted to decrease disease encounter. At the secondary level, comes early diagnosis and disability limitation by prompt treatment. The tertiary stage comprises late diagnosis and treatment, rehabilitation, readaptation, reeducation and maintenance of stability.

3. Breast-feeding : This provides ideal nourishment as well as immunological and psychological benefits to the infant. It avoids adverse effects of bottle-feeding like diarrhea, especially where there is no water sanitation. It provides an opportunity to detect and treat breast disorders. Where such disorders occur bottle-feeding should be substituted for breast-feeding, and the mother should be treated and rehabilitated.

4. Child-birth : The parents should be educated and prepared for natural child-birth. Classes should be given to both husband and wife. The disease encounter is decreased by avoiding episiotomies and anaesthesia for vaginal deliveries. The tertiary stage of prevention is to avoid caesarean section. Child-birth is a normal occurrence in life, like marriage, employment etc. Though fertility and child-birth in themselves are not a disease, an overload of them can cause stress and illness. Fertility has been prevented by the use of Condom, Intra-uterine device IUD), Pill, etc. Fertility is important to both men and women but in women, it has been interfered with to a great degree.

5. Reproduction : Primarily, the couple should be instructed on fertility awareness, and to use it, either to achieve or avoid pregnancy. They should not be advised about contraception right away, but when this is necessary, the natural methods should be taught to prevent the side effects of the artificial methods. This method will be more successful if there is better communication on the subject between the couple.

NUTRITION IN THE ADOLESCENT GIRL CHILD

Dr. Doren Fredrickson, Community Pediatrics, University of North Carolina, Chapel Hill, U.S.A.

1. The normal growth curve was displayed and the normal nutrition requirement for a child was given. The growth stops after the growth plate ossified in thelong bones, usually at puberty. It has been shown that in the present generation as compared to the older generation, people are taller.

2. Nutrition in girl children is important as they will be future mothers, and later on, produce healthy babies - which is required for a strong future generation. It has been seen that about one half of the world's population are girl children and, therefore, have half of the human intelligence.

3. The girl children in Delhi and the USA are found to be taller than those seen in Japan. Among the poorer girls in India, the height and weight are lower, and the menarche occurs at a later date.

4. Among the poor people in India, with lower height and weight and malnourishment, there is higher Infant Mortality than among those who are better off. Early pregnancy which is a very serious issue is the likely cause for this . Thus raising the age of marriage would lessen infant mortality. According to Indian law 18 years is the minimum age for marriage for girls, but this law needs to be rigidly enforced. Natural Family Planning, (NFP) will help in delaying child-birth. Better nutrition for girls, before and during pregnancy, will reduce infant mortality.

5. AIDS is caused by a RNA Virus HTLV III, and is mainly transmitted through sexual contact, blood transfusions, and needles for injections previously used by drug abusers. Symptoms are manifested six months to three years after the entry of the virus. Among children, the commonest symptom is diarrhea which goes on for a long period. Among Haemophiliacs who have received multiple blood transfusions, the disease has been detected 8 years after onset of disease. The risk factors among girl children are those seen in instances of prostitution, drug abuse and blood transfusions. Husbands or wives with girl children can also transmit the infection to girl children. The way to control AIDS among girl children would be to avoid sexual intercourse with prostitutes, and when injections become necessary, use sterilized needles; blood must be tested for AIDS virus before it is used for transfusion.

FAMILY PLANNING IN DEVELOPING COUNTRIES : INDIA

Keynote Address by Dr. J.J. Billings, Executive Director, World Organisation of Ovulation Method of Billings (WOOMB)

1. There exists throughout the world, particularly in affluent societies, and even amongst affluent individuals living amongst people of whom the majority are very poor, a deep level of ignorance about the socio-economic problems of the developing countries. It is often imagined that there is, in the poor countries, a degree of poverty which defeats, or almost defeats, any solution which human ingenuity might propose. Perhaps the saddest reaction of all is the fallacy which has deceived many people, that only a massive reduction in the birth rate will offer any chance of success.

2. These attitudes demonstrate that too little attention has been given to the significance of the word "developing". Very many of these countries have enormous natural resources, vast tracts of uncultivated, or primitively cultivated, fertile land; their people are intelligent and creative, and have cultural traditions which reflect a deep sense of the dignity of the human individual, and the importance of the family as the "first vital cell of society".[1]

3. There is, however, a deficiency of medical services and public health facilities. Amongst the most distressing effect of this inadequacy is the appalling infant mortality so often encountered. One has observed again and again, the sad plight of the young multipara, already old for her years, from whose succession of pregnancies, only a small number of children have survived. It is not the acquisition of material possessions, not even concern for the mother's health, so much as the confident expectation that the babies born will survive into adult life, that will initiate and sustain interest in the prudent spacing of births, by those who have the need to do so. There needs also to be social protection of motherhood, the true personal advancement of women, protection of the rights of migrants and other minority groups, and recognition of the place and proper role of aging persons in society. Development, if it is to be authentic, must be complete; it has to promote the good of every man and the whole man.[2]

The Family

4. In the Universal Declaration of Human Rights, the family is described as "the natural and fundamental group unit of society, ... entitled to protection by society and the State".

5. The individual family comes into existence when a man and a woman develop such a depth of love for each other that they make a permanent, public commitment that henceforth there will be not two lives but one. Each makes a gift of himself/herself to the other, a gift which is complete, acknowledging the two responsibilities involved in making the gift and in accepting the gift of the other person. This unique, exclusive love, spousal love, brings into existence an inherently indissoluble union of one man and one woman; therefore, its nature is designed for the procreation and rearing of children, and for fostering and sustaining the pledge of fidelity, which is the greatest gift they make to each other. In countries where marriages are "arranged, this spousal love is known to develop after marriage.

6. It is within the family that the child learns to love by being loved, to be just, to be honest, and to share. In the human heart there is a tendency to violence, which has always figured promi-

nently in human history. The great Chinese philosopher Confucius, born in the 6th century before Christ, taught us that " virtue is to love men, and wisdom is to understand men". "If there is harmony in the home", he said "there is order in the nation, and peace in the world". Pop John Paul II, in his Easter Message, *Urbi et Orbi*, 1985 gave an echo of those words when he said: "To be able to change structures, it is necessary above all to change hearts. Peace is born in the human heart and it dies in the human heart". The strong united family is the source of peace.

At the human level one can see the origin of the family in reproductive biology, in the physical helplessness of the infant, the emotional and psychological needs of the child, and also in the nature of the love for each other that a man and woman are capable of experiencing.

7. Love and life go together; conjugal love, spousal love, the greatest of all love between human beings, is of its nature, intended to be the origin of all human life. The child as well as the act of sexual intercourse, manifests the union of the spouses in one flesh. the Christian also understands that Christ made marriage a sacrament, so that now in all its beauty and strength, it is joined with the deep, faithful, exclusive love which characterises the covenant that god made with his people, and Christ with his bride, the Church.

8. When the word "resources" is used in economics, it should mean those things which can be used for the purposes of production. The principle resource is, therefore, labour itself, especially if it is skilled labour. An increase in population means an increase in the country's most important resource. It should be obvious that the strength of the country will be derived especially from the initiatives and vigour of its young people, and if there are to be young people, there must b babies. Those countries which do not too greatly restrict the birth rate will in the end prove to be the most prosperous George Bernard Shaw said more than 50 years ago, "The greatest service that can be rendered by anyone to the countr and to mankind is to bring up a family".

The Regulation of Births

9. It is sometimes imagined that the melancholic economist, Thomas Malthus, was the first to advocate population contro in his "Essay on the Principle of Population", written about 20 years ago. His mistake was to conclude that the number of people in the world increases in geometric progression, while food can only increase arithmetically; he had to assume that agricultural techniques were incapable of further development Actually the philosopher, Plato, some 2,000 years before Malthus had advocated population control, apparently because the city of Athens in which he lived seemed to him to be very crowded.

10. It is, however, in this century that the doomsday men have succeeded in creating a hysterical fear of population growth. In 1971, Dr Paul Ehrlich predicted, that in the 1970's the world would undergo famines; he said that "hundreds of millions of people are going to starve to death in spite of any crash programme embarked on now". He asserted that India was "so far behind in the population-food line that there is no hope that any food aid will see it through to self-sufficiency". India was doomed in his view to a disastrous famine from which nothing could save it, so that he actually recommended the suspension of food aid. His key assumption was that "each year,food production in the under-developed countries falls a little bit further behind burgeoning population growth'. this was a

remarkable statement in view of the fact that the statistics proved precisely the opposite. Even before that, however, the motives of those people promoting drastic measures of population control had been questioned. At the First united Nations world Population Conference, held in Belgrade, Yugoslavia in 1965, the view was expressed by a number of delegates that the birth-control programmes promoted throughout the developing countries really reflect the selfish purposes of international power, aiming at keeping prosperity in the affluent countries, and preserving wide areas of the world as resources of raw materials, a subtle kind of international aggression determined to preserve the domination of the rest of the world by the rich.

11. Although many good people have been misled by the relent less propaganda in favour of worldwide restriction of birth rates, it is now generally appreciated that neither the whole world nor any individual country should fear that development, and prosperity will be impossible of achievement if radical measures are not taken to restrict the birth-rate to replacement level or below. Much of the birth -control propaganda is now perceived to reflect the mixture of credulity, ambition and arrogance of those who have promoted it. Many reputable economists and demographers maintain that the world could in fact support an almost limitless level of population.

12. The avarice of the multi-national pharmaceutical companies has been manifested in promotion of their wares by bribery and dishonesty. Many persons with heavy investments in the pharmaceutical industries hold positions of influence in government, in the world bank and in various foundations, enabling them to determine to a large extent the volume of money allocated to birth-control programmes and the techniques which are promoted with in the programmes. Vested interests exist also in the poor countries. where a large bureaucratic structure becomes established and maintained by the hard currency provided by the rich countries; continuing employment, especially at the lower levels, is dependent upon the achievement of nominated targets.

In June 1988, the 22nd Conference of the Council for International Organisations of Medical Sciences was held in Bangkok, Thailand, organised by various international agencies including the World Health Organisation, the United Nations Fund for Population Activities, and the International Federation for Gynaecology and Obstetrics. The Catholic Church was invented and made a submission to the Conference, and pointed out that the right to freedom of conscience, and the right to information, requires that the primary and secondary abortifacient effect of so-called "contraceptive" medications and devices be communicated to the persons who will use or prescribe or provide that substance or device. The new drug mifepristone (RU486), various impregnated vaginal pessaries, and the intra-uterine device were taken as examples; also various contraceptive pills, and the WHO anti-fertility vaccine. The right of each person to good health places an obligation on researchers, promoters and providers of birth-control techniques,to communicate any possible harmful effects, including the long-term sterilising effects which are now well recognised. Also pointed out, was a lack of acknowledgement of the effectiveness of modern techniques of natural family planning, and a neglect of their beneficent influence in strengthening conjugal love and family solidarity. Finally, references were made to the AIDS crisis, with the reasonable demand that only methods of fertility control, which do not promote sexually-transmitted diseases, should benefit from research and funding.

13. There can be no doubt that when the history of this century comes to be written, the greatest prominence will not be given to the atomic bombing of Hiroshima and Nagasaki, or the Nazi extermination camps, or the millions of people killed by Stalin and his imitators, that the social phenomenon of widespread tolerance of induced abortion, which will be recognised as the most remarkable characteristic of ourselves, the people who lived during this 20th century.

14. It is unfortunate that many of those people who are appalled by the numbers of children killed before birth have accepted the fallacy, that the incidence of extra-marital pregnancies and demands for abortion will be reduced by the widespread distribution and ready availability of contraceptives. It has been shown all over the world that the more freely contraceptives are made available, the greater is the number of extra-marital pregnancies, the greater the number of abortions, and the greater the number of people infected with sexually-transmitted diseases. The failure of contraception to reduce abortions was acknowledged in the Report of the Secretary General of the United Nations Population Conference in Mexico City in August, 1984[3]. (E/Conf. 76/L.3., Mexico City, 14 August, 1944.)

15. It was only gradually that the close link between contraception and abortion came to be generally recognised. When the procreative potential of sexual intercourse is suppressed or destroyed, so that the act is regarded essentially as a source of physical gratification, there develops a resentment towards the child. In the first place, this is due to the fact that, when a man and woman engage in sexual intercourse, there is no technique for preventing pregnancy which is always effective, so that pregnancies will occur in spite of the application of the technique in the prescribed manner. More than that, the responsibility for the pregnancy is transferred to the technique itself, the man and woman feeling absolved from any responsibility towards the child. There becomes added a "small family mentality", which has important social consequences particularly in Europe, Japan, the United States of America and Australia. There develops an imbalance in the various age groups within the population, an increasing proportion of older people depending more and more upon a workforce of diminishing strength. The French historian Chaunu has stated: "In the last 20 years, western civilisation has undergone a demographic catastrophe, comparable only with the Black Death of the 14th century". The problems are compounded by a change in the whole nature of society produced by the influx of migrant workers and often by increased numbers of minority groups within the nation.

16. The demographers have made the mistake of regarding problems concerned with fertility regulation as primarily regional, or even national, instead of what really are, problems, of individual couples. There are literally millions of individual couples in the world in urgent need of help to regulate their fertility, either to achieve or to space pregnancies, yet, effective help has failed to reach the majority of them. A very serious mistake has been the application of coercive measures, designed to persuade the poor people to accept contraception, or more often, sterilization and even abortion. It is unfortunately true that members of the medical profession have often become agents of these anti-nationalist policies.

17. At the United Nations Conference on Population in Mexico City, already mentioned, it was recommended that "governments should, as a matter of urgency, make universally available family planning information, which should include National Family Planning, to ensure a voluntary and free

choice.

18. An Expert Committee of the World Health Organisation produced a satisfactory definition of Natural Family Planning (NFP) in these terms: "Natural Family Planning means techniques based on the timing of coitus with reference to the physiological manifestations of the fertile and infertile phases of the menstrual cycle, according to the intention of the couple to achieve or avoid pregnancy. `Natural' means that the use of medication, appliances and surgical procedures are avoided, and that the act of coitus is complete. It is implicit in the definition of NFP that there is abstinence from sexual intercourse, complete or incomplete, during the fertile phase of the menstrual cycle, if it is the intention of the couple to avoid pregnancy.

19. One of the arguments used against the implementation of a national programme of NFP is that it would take too long to produce the intended result. That never was a valid argument, and technological birth-control has had long time enough, far too long, to operate virtually alone in the field.

20. Repeated surveys have shown that those couples in serious need of avoiding pregnancy, whether as a temporary measure or permanently, are anxious to receive help that they find appropriate to their conscientious beliefs, and to their dignity as human beings. The Ovulation Method (Billings or BOM) of natural family planning provides a harmless, inexpensive and highly effective means of regulating fertility, which has been demonstrated to be acceptable to people of different cultures and religions, to be able to be understood and used successfully in different socio-economic conditions and be illiterate couples, in all the different physiological circumstances of the woman's reproductive life.

21. Despite the previous inability to provide for the recognition of returning fertility after childbirth, breast-feeding has always provided more spacing of pregnancies than all the birth-control techniques combined. The BOM now provides the means of recognising returning fertility, and therefore, provides for the full exploitation of breast-feeding as a means of spacing pregnancies, with benefits both to mother and child.

22. Christians are motivated by their Faith to recognise the dignity of the ordinary human individual, the sacredness of life before birth and every child as uniquely deserving of love and acceptance. They acknowledge the need to provide information which will enable people to regulate births in a responsible way, insisting upon the right of the husband and wife to decide for themselves, in the light of their own situation and their responsibilities to God, to each other, to the children already born and to society, how many children they wish to have. They will never be consumed by an obsessional fear of the child, nor by a morbid desire to persuade couples not to have children. The Christian philosophy of conjugal love and family life preaches a message of motivation, sexual responsibility, and of denying oneself for a greater good, presenting what St. Paul described as *caritas veritatis*, the charity of the truth.

23. The greatest strength of Natural Family Planning is the therapy which it exercises upon the family. The husband and wife learn to value and protect their fertility, to communicate with each other, and to understand each other better, and in all of this they perceive how truly the child is their greatest treasure, being the product of their love, their fertility and their union. It is thoughtless cruelty to tell the poor to solve the problem of their poverty by suppressing or destroying their fertility, thus depriving them of their most priceless possessions, and indeed their only treasures. This advice may

also be the manifestation of a contrived conscience, stifling the normal impulse to help those in need by portraying the poor as responsible for their own problems.

24. The woman's reproductive cycle is manifestation of God's creative intent at any particular time. In the generous acceptance of the need to postpone intercourse during days of possible fertility for the sake of the beloved and the whole family, they demonstrate to each other the depth of their love, and their submission to the dominion of the God they love.

25. When a woman gives herself to her husband in sexual intercourse she is asking to be loved tenderly. Natural Family Planning teaches her that she not a body to be used, but a woman-person and a wife to be loved. The man, and the woman too, are able to observe their love in action, and also the goodness of which they are capable, observations which make them better persons and more aware of the real meaning of human dignity.

26. In *Humanae Vitae*, Pope Paul VI said (N.21): "The right and lawful ordering of the births of children presupposes in husband and wife, first and foremost, that they fully recognise and value the true blessings of family life, and secondly, that they acquire complete mastery over themselves and their emotions". The mastery of self corresponds to the fundamental constitution of the human person. In this way natural family planning gives us deeper perception of the dignity of the human person, a vision of man which reveals humanity, the extraordinary image of God, which exists in human nature, the real meaning of love and deeper insight into just how **natural** family planning is natural.

27. Christians have many messages for the world. They can now be sure that the world is listening to the message of Natural Family Planning. Let us remember the words of St. Augustine: "Against the violence of love, the world is powerless".[4]

28. I remind you finally of the words of the poet prophet Isaiah: "Lift up your eyes and look at the Heavens? Who was it that made them?" (Isaiah 40:26).

REFERENCES

1. The Second Vatican Council, Decree *Apostolicam Actuositatem*

2. Pope Paul VI, Encyclical Letter "On the Development of Peoples", N.14

3. United Nations International Conference on Population E/Conf. 76/L.3., Mexico City, 14 August, 1944.

4. St. Augustine, *Enarrationes in Psalmos*, 48(47), 14; CCL 38, 548

The Basics of Natural Family Planning (NFP) and work at St. John's

Dr.(Sr.) Agostina Thomas, Head of the Department of Family Welfare and Fertility study
St. John's Medical College Bangalore, India

1. I would like to present briefly a short account on the basics of Natural Family Planning (NFP). The papers that will be presented during these two days will be highly scientific. Though there are about 52 gynaecologists and paediatricians and several general practitioners and directors of family welfare centres, all of whom will follow the presentations with ease, there is a small percentage of participants in this Conference who have not had significant exposures to this subject. I will not describe the method itself, as the time is limited, and also because we will be playing a video film this afternoon, which will explain the method in a simple and clear way that anyone can understand.

2 Briefly, NFP is not the old Calender Rhythm Method being presented under a new name. It does not ordinarily require long periods of sexual abstinence. The Ovulation Method which appeared on the scene in the 70's, and has become increasingly popular since then, is based on sound scientific principles, and its success is due to the precision with which ovulation can be predicted. The World Organisation of the Ovulation Method of Billings (WOOMB) and the International Federation for Family Life (IFFL) have undertaken the teaching of Ovulation Method and Sympto-Thermic Method in as many as 120 countries. In India, there are about 170 NFP Centres.

3 All Natural family planning method depend upon the biological fact that women are infertile most of the time. Even when allowance is made for the survival of the husband's sperm cells, within the woman's body, it is still true to say that an act of sexual intercourse, on the majority of days in the menstrual cycle, cannot possibly result in conception.

4 By definition, Natural Family Planning is planning for achieving or preventing pregnancy by the timing of intercourse. By observing and recording certain bodily changes that occur in a woman's menstrual cycle, and make use of this awareness, either to achieve or to avoid pregnancy. It is implicit in the definition of NFP that (a) drugs, devices and surgical procedures are not used, (b) when NFP is used to avoid conception, there is abstinence from sexual intercourse, and all genital contact, during the fertile phase of the menstrual cycle.

5 In order to define the limits of the fertile phase, we need information about:

(1) The time of Ovulation

(2) Ovum survival time: this is probably not more than a few hours.

(3) Sperm survival time; this is probably to be ;measured in minutes except in the presence of an adequate amount of cervical mucus with particular physical characteristics. Knowledge of the time ovulation and ovum survival time enables the post ovulatory phase of infertility to be defined and this infertility exists because the ovum is dead

6. Even though the role of mucus as a prospective indicator of

fertility has been recognised since 1932, the credit for the painstaking recording of the initial mucus observation, together with correlation of mucus and the cyclic hormones, is due to Evelyn and John Billings of Australia.

The Three basic methods of NFP are :-

A. Basal Body Temperature:

This is based on the fact that body temperature rises at the time of ovulation or shortly after. Three consecutive, undisturbed readings above the coverline indicate the beginning of the definitely infertile phase of the cycle. Success is dependent on the accuracy of temperature readings which are taken daily at the same time, whenever possible after rest or sleep Pregnancy avoidance or postponement necessitates abstinence until after ovulation.

B. Sympto-thermal Method:

This combines basal body temperature, cervical mucus methods, and calculations based on previous cycles to identify fertile and infertile times. Other factors which are taken into account are pain in the breast, tension, condition of the cervix, back pain, spotting etc.

C. Ovulation Method:

This is based on a woman's awareness of the changing pattern of cervical mucus which is produced during the menstrual cycle, and which defines possible fertility. It can be used effectively in every situation which occurs throughout a woman's reproductive life. It does not depend on regularity of cycles, or instruments. It defines both a preovulatory and postovulatory infertile phase of the menstrual cycle.

7. It is important to note that NFP is not a method of contraception, but a technique for determining the fertile period; abstinence during this period is what prevents pregnancy. The NFP methods are thus likely to be of interest to people who do not wish to use mechanical or pharmacological contraceptives for moral or other reasons

8 *Effectiveness of Natural Family Planning* : The effectiveness of many reversible method of family depends both on how well the users understand the method and on how well they use that knowledge. Effectiveness is expressed in terms of how many pregnancies would occur in 100 women who used the method for 12 months, thus one pregnancy would be equivalent to a failure rate of 1%. In some cases the method itself may be theoretically extremely effective, but the way it is used in practice may make it less so.

Potential demand There is no particular indication to follow the NFP Virtually all couples who want to plan their family can use NFP. A couple's chance of using NFP successfully increases if they are highly motivated, and enjoy good mutual understanding and communication The level of formal education does not appear to be a factor in a person's ability to learn NFP. In a WHO five-country study, 93% of the women representing a wide range of socioeconomic and educational levels, were able to identify correctly fertile and infertile phases, during the very first cycle following instruction in the Ovulation Method. In one centre, 48% of the women were illiterate and were as successful as women with post graduate education in two other centres. Most studies have rated the method 98-99% effective and that its effectiveness

is equal to that of the Minipill (and without its side effects), and higher than that of the Intra Uterine Device (IUD).

9 *Options* : Even if the need for NFP is not apparent in a community the family planning provider should be sufficiently familiar with the methods, to be able to explain them briefly to potential clients, and to refer those who express interest to an NFP service.

10. Those who adopt NFP find it easy, inexpensive, effective and free from side effects. It can be used from the first day of marriage, through the period of breast-feeding to menopause It is acceptable to all faiths. A study undertaken in Canada, USA and England shows couples reporting increased intimacy greater communication, and improved sexual relationship. NFP methods have been scientifically established and are reliable means to space births. They involve both the spouses, in dialogue and decision-making; Their use promotes love and maturity, intimacy and communication.

11. Why then has NFP not been ever more widely embraced? It is because this method is unfairly identified with the ineffective Calender Rhythm Method, that had many a limitation, and led to a high percentage of failures. Incentives are not offered in propagating NFP, and the number of committed NFP teachers are few. If the Government could take it up as one of the methods of family planning and launch a large scale operation many couples will benefit from this method. Understanding of periodic sexual abstinence is esental for the successfull practice of Natural Family Planning.

12. Some people may comment that the ideal family planning method should require no abstinence, and here they reveal a profound ignorance of human psychology. The development of maturity in the human personality depends upon the ability to exercise self-control, and this maturity necessarily implies control of the most urgent and pressing impulse for physical gratification, which lies within the realm of sexuality. No marriage is secure until the fidelity between husband and wife has been demonstrated by their ability to accept abstinence, the need for which inevitably occurs in marriage at one time or another.

13. Those who feel that abstinence during the fertile period, is a problem and hence there is no future for NFP in India, should know that to practice NFP, the couple indeed need self control. As a matter of fact it is the eastern religions such as Buddhism and Hinduism that passed on a wealth of spiritual and philosophical truths in the matter of love, sex, health and procreation, to the rest of the world. In Hindu literature and yogic practice, we are introduced to the concept of 'Life Force' that every man is endowed with. There is conscious effort to develop and to care for the 'Kundalini' the power of creation, and in order to save this energy, the couple practise abstinence and continence. In higher branches of Yoga, such as Raja Yoga, temporary and even long-term, celibacy is believed to contribute greatly to one's spiritual development. This also results in a calmer personality, deeper vision and inner power, and makes one a more loving and compassionate person with inner strength and control, over the basic emotions such a anger, sex desire etc. It elevates the conjugal love to a higher plane of mutual caring, devotion and understanding. In the Buddhist and Taoist belief systems, celibacy is believed to strengthen the life force. 'Humane Vitac' says that self-discipline brings to family life, abundant fruits of tranquility and peace. It fosters in husband and wife, thoughtfulness, trust and loving consideration for each other.

Natural Family Planning work at St.John's.

14. In St.John's, Billings Ovulation Method is taught to antenatal and postpartum patients in the Obstetrics and Gynaeocology wards, to the couples attending the Department of Family Welfare & Fertility Study and to those referred by other departments in collaboration with Community Medicine, to mothers attending the Mother & Child Health Programme in Rural Centres. The method is taught to the staff and their families in the campus and the employees of the various departments in the hospital and the college, are given informative talks group wise.

15. A complete course in NFP - approach and strategies, scientific basis and applicability, methodology and applicability of Billings, Ovulation Method (BOM) special circumstances in the reproductive life of the woman and the applicability of BOM in these circumstances, ; and respect for Life is given to the 7th & 8th semester medical students, 3rd year nursing students, B.Sc Nursing students of health care administration and the community health workers. A two session course is given to the Internees, while basic method-teaching is give to the Nursing Aids. In collaboration with the Obstetrics an Gynaecology Department. we have worked out a project titl 'Scope of successful practice of ovulation method in postpar tum breast feeding women. The aim if this project being. t evaluate the feasibility of successful practice of ovulation method of family planning in this group of women.

16. **Training Programme.**

The successful use of Natural Method of Family Planning requires a correct understanding of how the body works and a certain methodology how to use such a knowledge to advantage. To achieve this. teachers should be trained so that they could impart the knowledge to others. For those interested to learn the method and teach it to others we arrange an 8-10 days training programme twice a year and they are welcome to attend it.

A TRIBUTE TO MY UNBORN BABY GIRL

Go to sleep, my little baby girl,
I'll sing for you, a lovely song;
Sleep and dream your girl baby dreams,
And I'll be here all night long.
My sweetie pie, when you laugh,
The World will laugh with you;
My little baby girl, my lovely baby girl
You are mine, my very own;
A part of me, which none can deny.
For nine old months, in me you've grown.
My heart will fill with happiness,
When you smile and enter this world -
For it is me, and only me,
Who got you out, for all to see.
My darling one my own forever,
I'll love you and I'll protect you -
From this world of sorrow and pain,
And do for you all I can do.
I want nothing whatsoever in return
Except for one small wish;
Give me the freedom, the right, to love -
And make every mother wish for a child like you.

- Unknown

CHARTING INSTRUCTIONS

The Ovulation Method (O.M.) of Family Planning (F.P.)

The O.M. is a natural method of F.P. (N.F.P). It is based on the scientific facts that a woman can only become pregnant when she is in fertile period.

She can identify this fertile period easily by certain signs caused by the rise of female oestrogen (sex hormone)in her blood at this time. She does not need to be educated or have regular periods to use this method effectively.

These signs are :-

1. **Mucus** secretion from the cervical glands in the uterus (womb). This is **felt** as a **wet sensation** in genital area.
2. The mucus may be also **seen** as a raw egg-white discharge at this time.
3. There is **pain** in the lower abdomen on one side felt as a sharp pain. or backache often going down the thigh.
4. The breast feels heavy, and there may be a dull pain.
5. There may be a little bleeding or brownish discharge called midmenstrual spotting.
6. There may be mood changes. **The Strongest sign is the mucus**

Charting to detect your fertile period.

Mark your chart daily at night. Colour red in the square on the days you menstruate.

Menstruation is usually follwed by days of dryness. When th cervical glands begin to get stimulated by oestrogen they discharge a thick white secretion which marks the beginning o the fertile period and the woman begins to feel **wet**. Then it becomes thin and transluscent. (egg-white).

The wetness is a warning sign to the woman who wants to us the O.M. for F.P. She stops all genital contact with her husband She abstains for all these wet days or whenever she sees the secretion. The last wet day is called the **Peak Day** and it is followed by Ovulation. **i.e. Day 1.**

The ovum may live upto 18 hours so she abstains on **day 2** and **day 3** for safety. By the time she becomes infertile and can resume intercourse (The sperm or male egg can live upon 2 days in mucus).

Start charting immediately in the square corresponding to the day of your cycle e.g. the first day of your menstrual period is square 1. When kyou start a new cycle mark in this square (1) and write the date. Show your chart to a N.F.P. Teacher.

Mark Blue for **dry days** when **nothing** is felt. **Mark O** circle with a dot (sign of ovum) for wet days Mark a X on Peak Day which you will only know on Day #1 Mark in 2 and 3 on the following 2 days.

This Natural Family Planning NFP method is safe. effective and acceptable to all couples

THE MENSTRUAL CYCLE

The mucus pattern of fertility and infertility

COLOUR CODE FOR CHARTS

Bleeding

Infertile pattern of dryness

Possibly Fertile mucus

Peak: Maximal fertility

OPTIMISM WITH NFP FOR FERTILITY REGULATION IN INDIA - ICMR RESEARCH INTERIM

Dr. B.N. Saxena, Senior Deputy Director General

The Indian Council of Medical Research (ICMR) undertook the following three studies between 1986 and 1988 in order to ascertain the use-effectiveness of the Billings Ovulation Method (BOM) of National Family Planning (NFP), the profile and proportion of users of NFP, and the psycho-social perspective of NFP.

Pending the complete analysis, some of the interesting interim observations from these studies have been as mentioned below

Study 1 : Field Trial of Billings Ovulation Method of NFP

There is a large proportion of eligible couples who are not practising family planning, as the existing couple protection rate is about 37 percent (1986-87). These couples, and those who have discontinued spacing methods, are exposed to the risk of pregnancy. Can these couples, or a proportion of these, be protected from the risk of pregnancy through BOM of NFP? This was the implicit objective while assessing the use-effectiveness of this method in five states - UP, Bihar, Rajasthan, Karnataka and Pondicherry.

Out of 2081 married eligible women volunteers with normal menstrual cycles, 83.4 percent continued the method for 12 months, while 55.1 percent for 24 months. Among the discontinuers (16.6 percent at 12 months and 44.9 percent at 24 months) the reasons identified were, mainly, couple related, migration, switching over to modern family planning methods. Pregnancies were about 1 percent at 12 months and 2.1 percent at 24 months.

Study 2 : Baseline survey of users of Natural/Traditional Family Planning Methods and non-users of Family Planning who do not want additional children.

This study was carried out in five states - UP, West Bengal, Tamil Nadu, Gujarat and Jammu and Kashmir, with the main objectives of estimating the number of eligible couples who have ever used, or are currently using, natural artificial methods of family planning and studying the profile of such couples. The results based on the State estimates of 55,469 couples/ women against the sample 9,000, highlight that the percentage of ever users and current users of NFP ranged between 7 and 51 and 4 and 26 respectively. The main reasons for preference to NFP were, NFP is not inconvenient 9.8%), no expenses involved (16.0%), it does not disturb privacy (14.1%). The main reasons for discontinuation were husband's desire for children (33.5%), pregnancy (24.8%), fear of failure (21.3%) and troublesome to use (11.9%). The mean age of users, largely illiterate (56.4%) and poor, was 30 years. The average number of living children was 2.7. The religious and urban rural distributions of users did show secular trend of NFP use among the women of different socio0-cultural settings. A fairly large percentage of women (39), reluctant to use the modern family planning methods, expressed their willingness to use NFP in future.

Study 3 : A study of Psycho-social Perspectives of NFP in India

The above study was carried out in 3 States - UP, Rajasthan and Tamil Nadu. About 7000 married eligible couples (adopters, non-adopters) and 700 discontinuers of NFP methods, providers of health and family planning services were approached in the study, with the main objectives of understanding the knowledge and practice, reasons for adoption, non-adoption and discontinuation, of modern family planning methods, and assess their willingness to use NFP in the background of their profile. Providers' willingness to use educate and advocate NFP to couples was also implicit in the study. The observations reveal that the knowledge of NFP among the couples was very poor. However, there was a strong preference among them for NFP Given the knowledge, a large majority of them in Rajasthan (67.12%) would have practiced NFP methods, for it is easy to use them, they are free from complications, and there is no dependency on the availability and supply of these methods, as against the dissatisfaction with the modern family planning methods, mainly due to the physical problems.

Possible Policy Implications of Natural Family Planning Methods

Persistent high birth-rate (around 31 per 1000 population) stagnating from last decade, coupled with high maternal (about 4 to 7 per live births) and infant (around 91 per 1000 live births) mortality rates along with their associated morbidities programme managers in the country India was the first country in the world to have started, as an act of faith, the national family planning programme in the 50s. However, the impact of this programme has not been significant on the above health indicators, due to several reasons, for example - unachievable targets were set, and too much emphasis was placed on "hardware" i.e., technology, rather then understanding that family planning also requires "software", i.e., human touch and understanding.

New Programmes

1. The new programme of the Government of India is likely to adopt life-cycle approach to cover all ages of women-with special emphasis on adolescent girls/young women (7-19 Yrs of age), for family welfare programme. In this regard, the health education component of natural family planning methods with emphasis on family life education component of natural family planning methods with emphasis on family life education and reproductive biology & x education, will be important entry points for improving women's health and development, preparing them for safer and responsible motherhood.

2. A disaggregated and decentralised approach will be utilised in VIII plan with special emphasis on UP, MP, Binar, Rajasthan and Orissa.

3. With more field experience available in coming years, it is likely that natural family planning may be included in the package of the national family planning programme.

NATIONAL FAMILY PLANNING IN INDIA

Study by Indian Council of Medical Research (ICMR)
Dr. B.N. Saxena, Senior Deputy Director General and
Dr. R.N. Gupta, Assistant Director General

It emerges clearly from the interim analysis of the ICMR Task Force studies in natural Family Planning (NFP) that the NFP is compatible with Indian Culture and also offers a secular option to many Indian couples.

A survey of users of natural/traditional family planning (F.P.) methods and non-users of F.P. who do not want additional children, which was entrusted to the Operations Research group, Baroda, covering 55,469 married eligible women in 5 distinct socio-cultural settings states) of the country revealed that the knowledge about NFP methods among the women was very poor, and only one or two methods were known to them. The percentage of ever users and current users of NFP ranged between 7 and 51 & 4 & 26 respectively. The main reasons for preference to NFP use were, NFP is not inconvenient (49.8%), no expense is involved (16.0%), and it does not disturb privacy (14.1%). The main reasons for discontinuation of NFP use were, * (21.3%) and troublesome to use (11.9%). The mean age of the users, largely illiterate (56.4%) and poor, was 30 years. The average number of living children was 2.7. The religious and urb rural distributions of users did show a secular trend and cultu compatibility of NFP use among the women of different soc cultural settings. A fairly large percentage of the couples (3 reluctant to use the modern F.P. methods, expressed th willingness to use NFP in future.

Another study, Psycho-social Perspectives of NFP, which w entrusted to the Indian institute of Health Management Researc Jaipur, covering a sample of 2400 couples and 240 providers Health & F.P. Services , revealed that both the couples ar providers had very poor knowledge about NFP methods. Hov ever, there was a strong preference among them for NFP. Give the knowledge a large majority of them (67.12%) would hav practised NFP methods, for it is easy to use them, they are fre from complications, and there is no dependency on the availabili and supply of these methods as against the dissatisfaction with th modern family planning methods, mainly due to the physica problem. The study indicated that the younger husbands (25-3 years) and their wives (20-39 years) were more susceptible t ;contraception. The nuclear families showed a higher trend c adoption and discontinuation of artificial F.P. methods However, no extreme trends emerged across social classes castes and religions with respect to adoption or non-adoption or discontinuation of F.P. methods.

* husbands' desire for children (43.5%), pregnncy (24.8%), fear of failure.

CHARACTERISTICS OF OVULATION METHOD ACCEPTORS A CROSS-CULTURAL ASSESSMENT.

Hanna Klaus, Miriam Labbok and Kianne Berker

Five programmes of instruction in the Ovulation Method (OM) in diverse geographic and cultural settings are described, and characteristics of approximately 200 consecutive OM acceptors in each program are examined. Major findings include: the variable, as is the level of previous contraceptive use. Acceptors are drawn from a wide range of socioeconomic and religious background: however, family planning intention was similarly distributed in all five countries. In sum. OM is accepted by persons from a variety of backgrounds within and between cultural settings. (STUDIES IN FAMILY PLANNING 1988)

1. The Billings Ovulation method is based on self-observation of a sequence of changes in the quality and quantity of cervical mucus in order to determine the fertile period of the menstrual cycle. The Ovulation and other periodic abstinence methods have been promoted by the Catholic Church and other groups as the natural approach to family planning, including child-spacing, limiting family size, and achieving for individual programs, although the Ovulation method is practiced world wide by women in a variety of cultural settings. The assumption is often made that acceptor couples are Catholic, well educated and highly communicative. The objectives of this study are to describe this sample of OM acceptors, and to assess social and cultural factors associated with method acceptance.

Programs and Data Collection

Five programmes were selected for a comparative study of socia-cultural characteristics across diverse geographic settings. The programmes in Bangladesh, India, Kenya, South Korea and the United states were developed to meet the needs of those who for religious, cultural or medical reasons preferred this method, or found other methods unacceptable (Gomes, 1988). These programmes are described below.

2. The Natural family planning programme in Bangladesh was begun in Dhaka, the capital city, in 1976, and initially operated through the parish structure of the Catholic Church, hence attracting a predominantly Catholic clientele (Gomes, 1988). A client is considered an 'Acceptor" after the initial three months of instruction, and 'autonomous' when she is skilled and confident enough to use the method without guidance (Ahmed *et al.*,1985) In December 1983, the programme included 823 autonomous and 1,116 non-autonomous users, in 13 of the 21 districts of Bangladesh. As of March 1986, 2,382 autonomous and 2,107 nonautonomous clients had been or were being trained at 41 subcenters (Gomes,1988). A sample of 270 consecutive acceptors in the OM program was collected starting in October 1983. The sample consisted of OM acceptors, as defined above for Bangladesh. Baseline information was collected by interview for 255 of the women, and from program records for the remaining 15.

3. The Tamil Nadu family development centre in India offers OM to meet the needs of those who, for religious, cultural or medical reasons, prefer this method or find other methods un-

acceptable. The program operated 566 sites in 1986. with 108 full-time teachers and about 12.000 clients per year.

4. Data were gathered from a sample of 198 consecutive new admissions to the OM program from October to December. 1983. Baseline information for 47 cases was collected by individual interview, while information for the remaining 151 cases was drawn from program records.

5. The family life program in Eldoret Diocese, Kenya. was established in 1975. A sample consisting of 200 consecutive users at the time of achieving autonomy in OM was collected: all 200 couples were interviewed upon achieving autonomy. The Korean Happy family movement (KHFM) operates through the Catholic church. and was begun in all 14 dioceses of Korea in may 1975. A sample of 200 consecutive acceptors of the program was collected, and all were interviewed. Finally. the natural family planning centres of Washington. D.C. : St. Cloud, Minnesota: and Corpus Christi, Texas, were included in this study. A sample of 149 Consecutive admissions to the three programs was collected.

6. **Methods**

Data were collected as described above on a form designed by the Natural family planning centre, Washington. D.C. These forms were then forwarded to the Johns Hopkins school of Hygiene and public health. in Baltimore. for data handling and analysis.

7. **Findings**

The average age of acceptors in each country did not vary significantly from the mean. Per cent distribution by religion did show differences among programs: Kenya was predominantly Catholic. while only 34 per cent in the Bangladesh program were Catholic. Those attending as couples varies from a high of 85 per cent in Kenya. to a low of 39 per cent in India. Differences of religion within couples were most common in Korea, but constituted only 7 per cent of all couples.

Large variation is evident in educational attainment among countries and between men and women. the men in all five countries are generally more educated. Except in the US. the median number of years married varied around nine. and the average number of living children varied around three in a similar pattern. There was no predominance of male or female children.

8. Couples in Bangladesh India and Kenya were more likely to have experienced child loss and less likely to have practised a family planning method in the past. The average desired family size. given present children was 3.4 in Bangladesh. 3.2 in India. and 6.3 in Kenya. all well below the present total fertility rates (TFRs) of 6.2. 4.8 and 8.0. respectively (Birdsall. 1984).

9. "Family planning worker" and "Health reasons" were the referral source and reason for acceptance cited most often. however. it should be noted that "family planning worker" includes workers who were promoting the Ovulation method only. Family planning intention was similar across countries. with the exception of the US and Korea where there are more "unknowns" Korean and US acceptors in each category. had slightly fewer children. as well. Achievers generally reported fewer children.

10. Autonomy was achieved at slightly less than four months on average previous family planning use as a determinant of discussion concerning family size. Nearly all couples in union (over 90 per cent overall on average) do discuss this subject, with previous use having no apparent effect. The relationship between educational level and discussions concerning desire for intercourse by the couple was assessed such discussion was reported less often in the more developed countries. When controlling for educational level, this relationship remains. There is no consistent relationship between education and these discussions among the developing countries studied.

Discussion and Summary

11. This study has addressed several questions of interest to family planning servic providers. Primarily, some insight is provided into the veracity of several existing myths about acceptors of the ovulation and sympto-thermal methods, and allows a closer look at cross-cultural variations.

12. One often-mentioned myth is that acceptors are solely religiously motivated. However, we have shown that, while all except two US programs were Catholic church-based, members of other religions were well represented. In sum, although Catholics joined these church-based programs in much higher percentages than they represent in the population as a whole, the representation from other religious groups was much higher than might have been expected if religion alone were the major motivating force.

13. Another myth is that the ovulation method and other methods reliant on signs and symptoms and periodic abstinence cannot be learned unless marriage partners receive the instructions together. The ovulation method is a 'couple method', yet many women attended the instruction meetings without their male partners in all programs. Despite the fact that one-third of the Bangladeshi, and over two/thirds of the Indian, clients were not taught as couples, both partners had to cooperate if the method was to be effective.

14. Acceptors chose to use OM for a variety of reasons. While religion is mentioned by more than 50 percent of US and Korean acceptors, this may be underreported in the Bangladeshi, Indian and Kenyan programs because the worker was identified as belonging to a church-based programe: hence, the client may have considered the religious motivation as self-evident. Economic and health considerations were very important. Specified items in this category included the experience or fear of side effects with oral contraceptives and IUDs. In Kenya, 33 percent stated that they had enrolled for the purpose of sex-selection that is, the desire to choose a son.

15. It should be pointed out that family planning intention is not static. Only 3 percent of couples entered the programme with the intention of achieving pregnancy. The percentage of couples who discuss family size does not seem to be influenced by prior family planning experience. Not only culture, but the requirement of OM may be more important determinants of conjugal discussion about intercourse than educational level. Based on discussions with a number of acceptors from the various study sites, it is clear that couple communication is mandatory for OM use, and the effect of this communication is not limited to sexual intercourse but has been shown in follow-up discussion to extend into many areas of a couple's relationship (Klaus, 1987).

16. In sum, this study has shown the following:

- Acceptors are not necessarily religiously motivated.
- Many acceptors attend instruction sessions alone in all programs.
- Acceptors come from a variety of socioeconomic backgrounds and previous family planning experience.
- OM is used in populations with widely varying fertility goals.
- The percentage of couples who have discussed family size is not apparently influenced by prior family planning experience.
- Education level does not appear to be associated with a couple's willingness or ability to discuss sexual intercourse.

The implications of these myth-breakers are that the ovulation method has a wide and diverse potential audience, and that neither previous family planning use nor level of education has a major influence on the level of a couple's communication.

17. Conclusions : While much work remains to be done before motivation to accept specific family planning methods is completely understood. this study has addressed several issues that should be of interest to family planning service providers. Perhaps the information provided here will encourage wider discussion and consideration of provision of the ovulation method. and greater emphasis by service providers on understanding couples' needs and interactions.

CAUSES OF INFERTILITY AND THE ROLE OF NATURAL FAMILY PLANNING IN PROMOTING FERTILITY.

Dr. R. Narayanan, Professor & Head of the Department of Obstetrics & Gynaceology,
St. John's Medical College Hospital, Bangalore - INDIA.

1. To treat infertility, one has to understand the principles of fertility and hence, it is essential to be familiar with the physiology of reproduction.

Physiology or reproduction :

2. The hypothalamus situated in the brain secretes gonadotropin releasing hormones (GnRh). in response to various factors such as environmental changes and stress. The control of the secretion is influenced by the feedback obtained from circulating hormones. GnRh acts on the anterior pituitary to stimulate sequential secretion of gonadotropins (FSH & LH). The gonadotropins act on the gonads. the testis in the male and the ovary in the female. which in turn release androgens, oestrogens and progesterone, as required.

3. In the male, the testis is the seat of spermatogenesis. The sperms which are produced, are matured in various stages, and transported to the urethra, via vas deferens along with the secretions of prostate and the seminal vesicles at the time of ejaculation. In addition, the testis secretes testosterone in response to hormonal stimuli. Testosterone is responsible for erection, emission and ejaculation. Therefore, for a man to be fertile he should be able to produce an adequate amount of healthy spermatozoa, and he should also be able to perform a normal sexual act.

4. In the female, a dominant graffian follicle matures under the effect of FSH during every menstrual cycle. A surge of LH from pituitary releases the ovum from the follicle at ovulation. The ovum is then picked up by the fimbriae of the fallopian tube and is propogated towards the uterus by ciliary movements. If coitus takes place at the time of ovulation, the sperms ascend through the favourable cervical mucus into the uterine cavity, and then into the tube. Fertilisation takes place inside the fallopian tube, and the fertilised ovum undergoes division and moves into the uterine cavity. The fertilised embryo thus gets embedded in the endometrium which has already prepared by progesterone.

Definition of Infertility:

5. Infertility is a condition in which a woman is not able to conceive within 1 year of commencing and continuing regular, unprotected sexual intercourse.

6. **Causes of Infertility:**

Male		Female	
Testis :	Absence	Vagina :	
	Undescended testis		Absence
	Infection		Anomalies
	Damage to the testis		Stenosis
	Tumours		Dyspareunia
	Abnormal temperature		Infections
Varicocoele			
Prostate :	Damage	Cervix :	Trauma
	Infection		Inflammation
	Neoplasm		
Urological problems		Uterine :	
			Double/ Septate uterus
			Infection
			Injuries
Vas - Epididymis :		Tubal factors :	
	Vasectomy		Hypoplasia
	Trauma		Obstruction
	Obstruction		Infection
	Inflammation		Dysfunction
	Congenital absence		Adhesions of tube
Penis :		Ovary :	
	Congenital anomalies		Anovulation
			Luteal phase defects
Functional abnormalities :		Other Diseases :	
	Impotence		
	Premature ejaculation		Endometriosis
	Retrograde ejaculation		Infection
	Azoospermia		Tumours
	Poor quality semen	Peritoneal :	
	Endocrinological causes		Adhesions
			Endometriosis

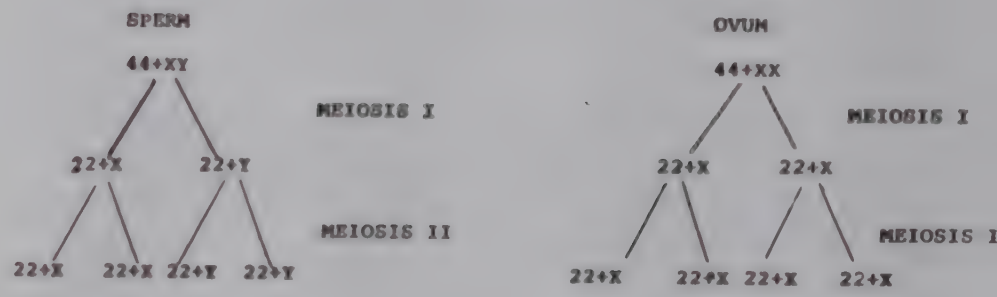
venipuncture) is implanted in 5 c.c.of medium containing phytohemagglutinin, which stimulates mitosis. The blood cells are grown in culture bottles for 72 hours at 37°C. Two hours prior to harvesting of cells, colchicine is added to arrest the cell growth, so that some cells are arrested at metaphase. After 72 hours the cells are separated and treated with hypotonic solution, and then with fixative. The slides are made by dropping the cells on the slide from a height. The metaphase spreads seen under the microscope are photographed, and a karyotype is made by cutting around the chromosomes, and arranging them according to the International Classification (Paris) from Nos. 1 to 22 and the 2 sex chromosomes. The karyotype of a female is 46, XX, i.e., she has 46 chromosomes, and the sex chromosomes are XX; the karyotype of a male is 46, XY, i.e., he has 46 chromosomes, and the sex chromosomes are XY, (Fig. - I). The Y chromosome is easily identifiable, as it is shorter than the X and usually has parallel arms.

6. In a pair of chromosomes, one chromosome comes from the father and one from the mother. That is how we inherit the characteristics of both the father and the mother. By various types of staining procedures, occasionally, we can make out whether a chromosome is paternal or maternal. Among the 2 X (sex) chromosomes in the female, one comes from the father, and one from the mother, whereas in the male, the X chromosome is always from the mother, and the Y chromo some is always from the father.

7. To understand this, the fate of chromosomes during fertilization should be looked into. We have diploid set of chromosomes (46). If the ovum had 46, and the sperm had 46, then, the embryo would have 92 chromosomes, and for the embryo to have 46 chromosomes, the ovum and sperm should have haploid set of chromosomes, i.e., 23. Hence, there has to be a reduction-division from 46 to 23 in the ovary and testi This reduction-division is called Meiosis. Meiosis is gonads essential for continuation of any species. (Figure - II).

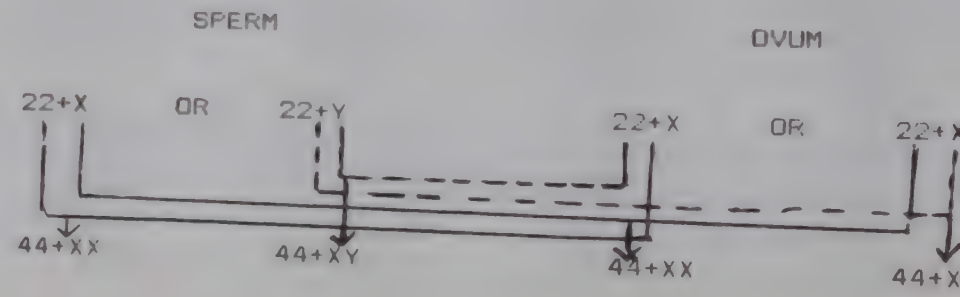
FIGURE - II

MEIOSIS



8. During fertilization, the sperm and the ovum each contribute one sex chromosome. (Figure - III).

FERTILISATION



From the above it is obvious that only sperms could be male or female, carrying either X chromosome or Y chromosome, and they could fertilise the ovum which will have only 22+X chromosomes, giving rise to either male or female children. Thus the father is genetically responsible for the sex of the child and not the mother

9. During meiosis abnormalities could occur. This is called non disjunction. (Figure - III and IV).

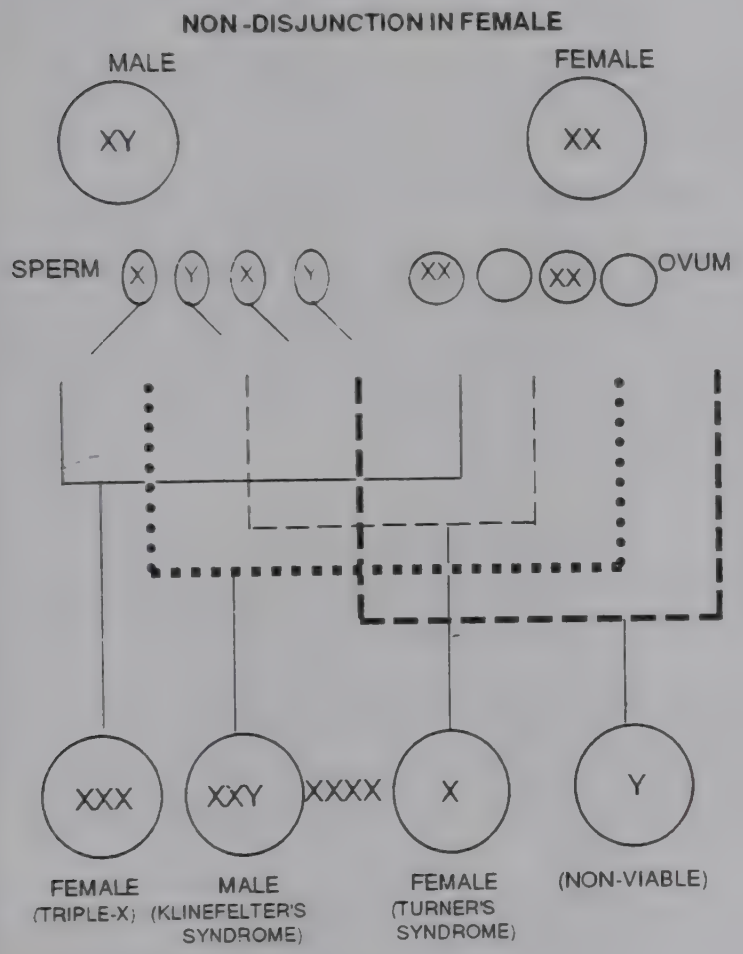


Figure III

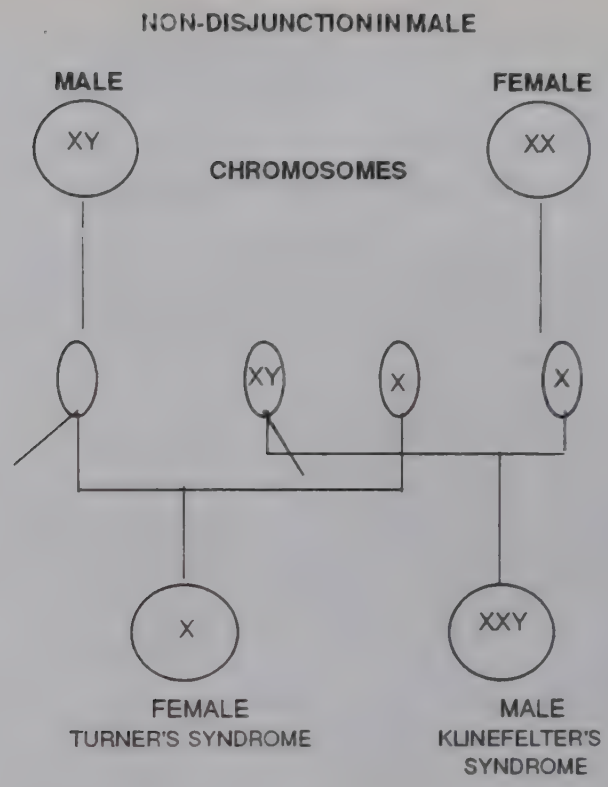


Figure IV

10. **Abnormalities of sex chromosomes in the female:**

(1). Numerical (2). Structural

Numerical : Turner Syndrome

Karyotype is 45, X i.e., they have only 45 chromosomes with only one X chromosome. Usually, these patients come for amenorrhoea (not getting menstrual periods) or rarely for short stature. On examination, they will have. besides short stature, shield chest, wide-apart nipples, no secondary sexual char-

acteristics (like breast development or hair growth in the axilla and pubic region), neck webbing (very rarely seen) and cubitus valgus.

46 XX/ 45 XX: (Mosaic Turner Syndrome)

They have a normal cell line, and an abnormal cell line, i.e., XO. They resemble Turner in almost all the features, except that they may have slight breast development, and spotting and irregular periods.

47, XXX : Triple X Syndrome :

These patients are usually fertile, but occasionally come with gonadal dysgenesis with amenorrhoea and poorly developed secondary sexual characteristics. They have one extra X chromosome.

Structural abnormalities of the X chromosome

There could be deletions, additions, ring X chromosome and fragment X chromosome. All these resemble Turner Syndrome.

Fertility in Turner syndrome and Turner Variants :

They are usually sterile. However a very few cases (8) have been reported in the world literature where Turner syndrome patients have been fertile after treatment.

Numerical abnormalities in the male :

Klinefelter syndrome (KS) 47, XXY. These have one extra X chromosome. They are usually sterile. They have hypogonadism and gynaecomastia (breast development). Body proportions and fat distribution could be that of a female. Mentally they could be intelligent to severely retarded. KS could be found among professionals to people who have been institutionalised for mental retardation.

Klinefelter variants :

46 XY/47 XXY Where one cell line is normal and one abnormal. Features are similar to that of KS. They are sterile.

48 XXXY and 49 XXXXY : Klinefelter syndromes with severe mental retardation. As the number of X chromosomes increase the mental retardation also increases.

XY : this is a separate syndrome. These men are usually tall fertile, but may slightly increased criminal tendencies than the normal population. In the beginning they were found in basket ball teams in prisons Hence they were dubbed to have criminal tendencies.

Structural abnormalities of Y chromosomes :

The length of the Y is variable but usually same in a family. The length of the Y usually depends on the length of the fluorescent part of the "Y" chromosome. Deletion of the lower fluorescent part of the Y chromosomes is not deleterious, but the loss of any other part of Y chromosome can lead to sterility or ambiguous sex.

Fertility Failure : Chromosomal translocation i.e, exchange of one part of the chromosome with another or one whole chromosome attached to another can lead to recurrent abortions. Usually these are balanced translocations in the patients.

The study of abortuses has shown that 40% to 80% of the spontaneously aborted foetuses are chromosomally abnormal. However, studying a foetus for chromosomal abnormality does not usually help in counselling but helps in understanding why the abortion has occurred.

Others : Some of the autosomal trisomies (3 chromosomes instead of a pair) and translocations could lead to infertility.

CERVICAL MUCUS AND BBT IN TREATMENT OF INFERTILITY

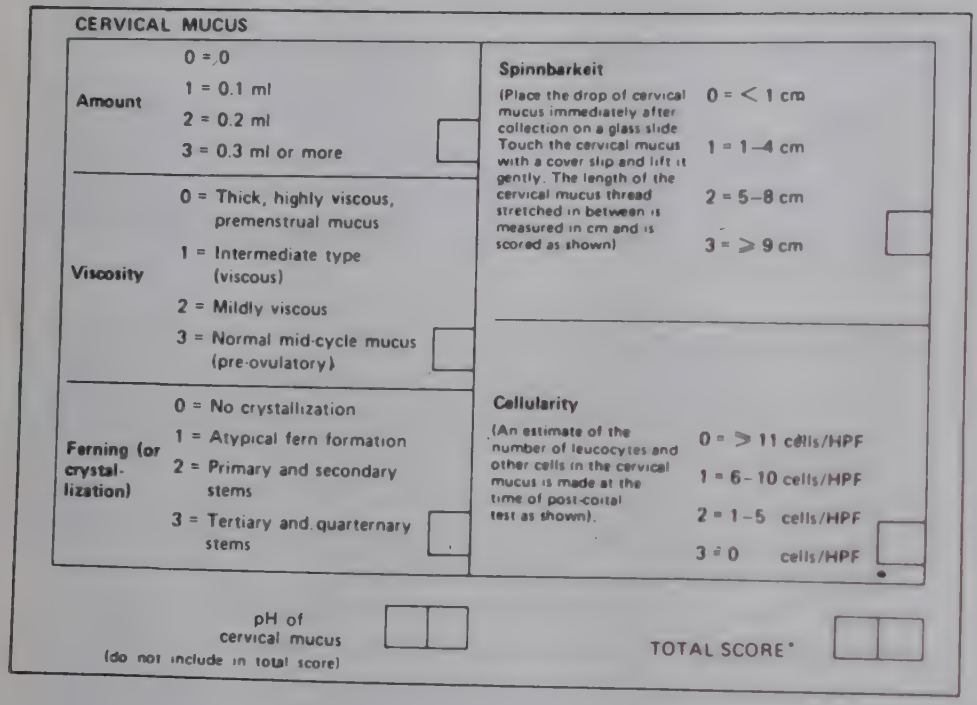
Dr.Sr.T.Lillian,'Associate Professor, Dept. of Obstetrics & Gynaecology, St.John's Medical College, Bangalore.

1. Ovulatory dysfunction has been proved to be a major factor causing infertility. The role of luteal deficiency, as described by Jones, in causing infertility, and early 1st trimester abortion, is being recognised in recent years. The diagnosis of these conditions is done now-a-days through sonological folliculography, midcyclic LH or midluteal progesterone assays, and endometrial dating. These sophisticated tests are more invasive, and are to be done frequently, and hence, not practical in a simple set-up. Periovulatory changes in blood levels of oestrogen and progesterone produce recognisable peripheral effects like characteristic cervical ovulatory mucus, and biphasic body temperature shift. The cervical mucus and basal body temperature studies are widely used, because of their simplicity and practical usefulness, to diagnose and monitor the treatment. While cervical mucus predicts the time of ovulation, BBT is an indicator, not only of the ovulation which has just occurred, but of various follicular and luteal phase defects.

2. *Cervical Mucus* is an inbuilt indicator of fertility in the woman. This was reported by Smith as early as 1855, that conception was most likely to occur when the mucus was "in its most fluid condition", and Sims, in 1868 described the mucus as best for sperm health at post-coital test as "clear and translucent and about the consistency of white of egg". John Billings recognised the significance of mucus as a marker of ovulation. Professor Odeblad of Sweden (1950) demonstrated 3 types of mucus, L & S type and G type produced by cervix. The oestrogenic EL & ES mucus is produced before ovulation under the influence of oestrogen. EL type of mucus, characterised by "beads" or "loafs" of mucus, is protective and capacitative to sperms, and also filters off the defective sperms. The S-type stretchable mucus, with its lubricative quality, has hundreds of channels for easy passage of sperms and indicates a high level of fertility.

3. Soon after ovulation progesteron from corpus luteum stimulates production of gestagenic G-mucus, composed largely of protein fibres forming an inpenetrable barrier to sperms. Characteristic changes in cervical secretion, indicating ovulation are (1) Change in sensation-slippery lubricating, at ovulation (2) Change in consistency, copious, transparent and stretchable as the "white of an egg" (Spinbarkeit). The last day on which the mucus becomes clear, stretchy and slippery, is referred to as"peak mucus symptom". Ovulation occurs on an average within 14 hours of the peak symptom. Soon after ovulation, the mucus becomes thick and tachy and disappears in 2-3 days. The woman is easily taught to note and chart her mucus pattern and thus identify the ovulation, in order to time the coitus. *For figure see page 63*

4. *Cervical mucus score* is ascertained to assess the role of mucus in fertility, based on the quantity, viscosity, ferning. spinbarkeit and cell count of the cervical mucus, giving 0-3 points for each. A score of 15 is considered to be very good, less than 10 poor and less than 5 is hostile.



5. *Cervical mucus hostility:* Huhner's post-coital test involves study of a mucus sample, 4-12 hours after coitus, around the peak mucus period. It may indicate compatible sperm mucus penetration, or a hostile mucus, disorders of sperms, and the presence of sperm antibodies which destroy or damage the sperms.

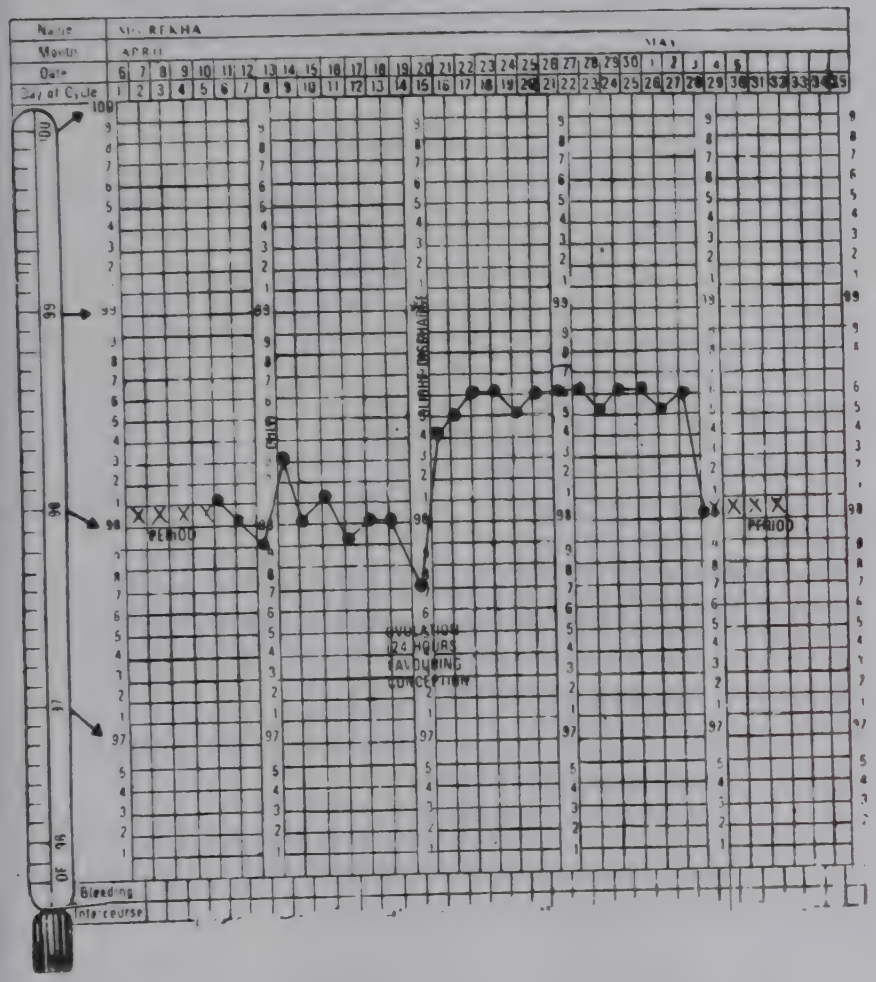
6. Clomid which is used to induce ovulation, being a mild antioestrogen, is said to have an antagonistic effect on cervical mucus secretion. but probably not with a pharmacological dose. Poor cervical mucus with clomid therapy is 10.6% - 15% which is not more than general incidence among infertile patients. But some have found that small doses of oestrogen improve the quality of cervical mucus for successful sperm penetration.

7. *BBT and Infertility*
The hormone progesterone. produced by the corpus luteum after ovulation, being thermogenic, causes a rise in the body temperature by about 0.3 c - 0.6 c. Marshall (1963) in his study of thermal changes in 1088 menstrual cycles with ovulatory biphasic shift, described 3 patterns:

1) Acute rise with a rise of 0.2 c at least between 2 consecutive days.
2) Slow gradual rise over 3-5 days.
3) Step-ladder pattern.

The temperature dip prior to the rise may indicate. if noted, the precise time of ovulation. The dip was noted only in 10% of cycles according to Marshall and 16% in Hilger's and Bailey Series (1980). A sustained shift to a higher temperature on 3 consecutive days is the criterion for recognising the ovulatory event. Hilgers and Bailey showed that the estimated time of ovulation (ET) deduced from early rise of progesterone, occurred within + 2 days of temperature - nadir (1st day of temperature rise) in 80% of cases and of coverline endpoint (day before temperature rise) in 77%. Thus BBT, though not a precise predictor of ovulation. is widely used being simple and practical. A special thermometer with expanded scale is used for easy reading by the woman who notes her tempera ture daily on waking at basal conditions, and charts it. Biphasic shift of BBT confirm the occurrence of ovulation.

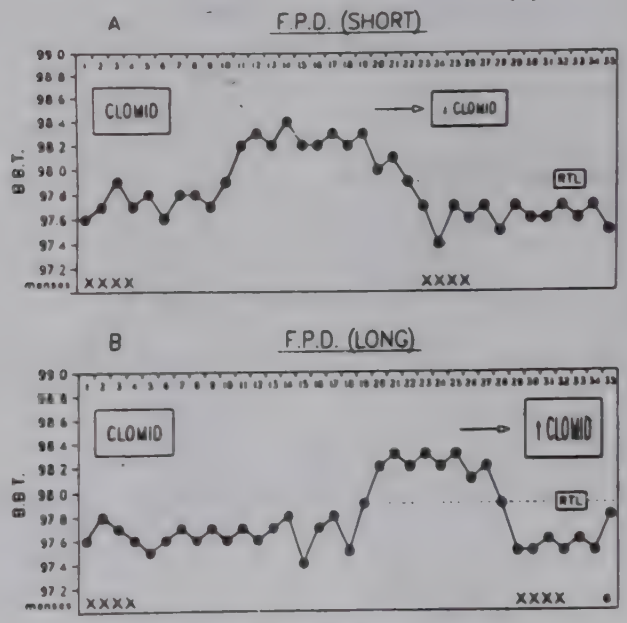
THE *Basal* TEMPERATURE CHART



8. *BBT and ovulatory problems*
Various abnormalities of ovulation seen, especially while treating anovulation with ovulation induction agents, will be reflected on the BBT chart. Thus it helps in assessing the problem, and monitoring the treatment.

9. *Anovulation:* BBT monophasic, no biphasic shift noted. Ovulation is induced with clomid, if endogenous oestrogen is sufficient, indicated by a positive progesterone challenge test. Those with insufficient oestrogen will be helped with hMG/ hCG therapy.

10. *Follicular phase defect (FPD)*
    i) Short FBD: The follicular phase is less than 11 days as shown in BBT, and usually suggests premature ovulation, or hyperresponsive ovaries to the treatment. Clomid administration in reduced dosage in the next cycle is of help
    ii) Long FPD: A prolonged follicular phase (>16 days) suggest inadequate endogenous gonadotropin in the early part of the cycle: clomid administration in increased doses may be useful.



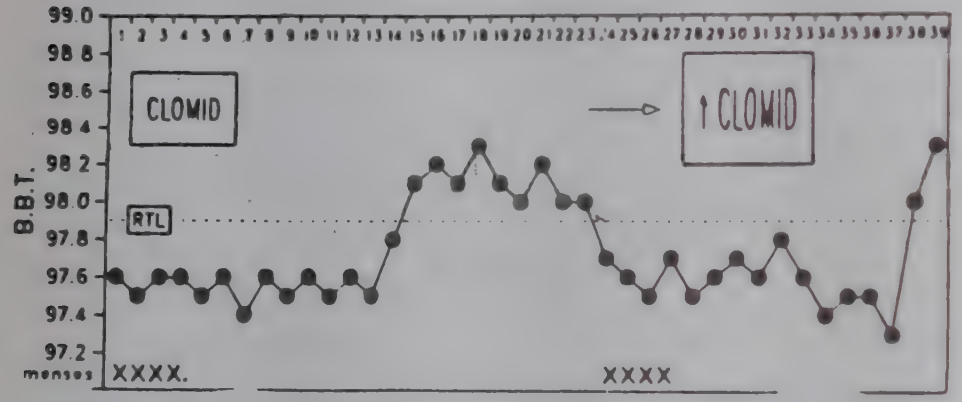
Basal body temperature record in follicular-phase defect. RTL, reference temperature line.

11. *Luteal phase defect: (LPD):*

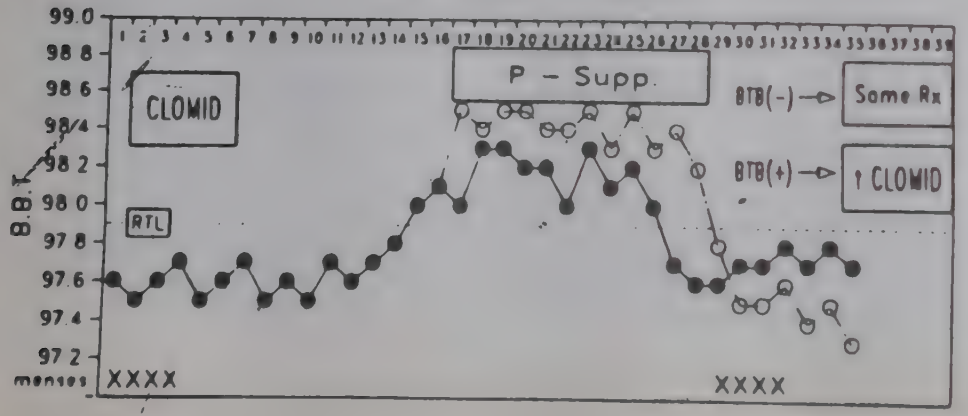
i) Short LPD: BBT charts show a luteal phase of less than 11 days, probably due to abnormal folliculogenesis with in sufficient gonadotropin. Endometrial stromoglandular asynchrony and luteal lag may be noted. Increased dosage of clomid in subsquent cycle may be helpful.

ii) Inadquate luteal phase defect: It is due to defective luteal function with reduced progesterone secretion. BBT chart shows slow rates of temperature rise. There is endometrial luteal laq, with stromoglandular asynechrony. Supplemental therapy with progesterone suppository (25 mgm twice daily) has proved to be successful.

A L.P.D. (SHORT)

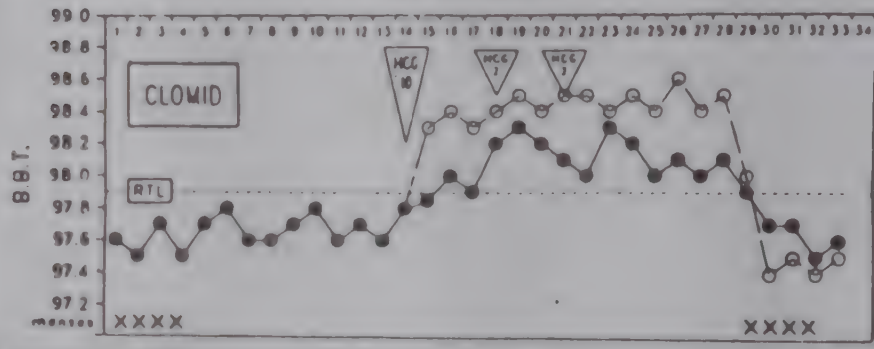


B L.P.D. (INADEQUATE)



12. *Abnormal LH Surge:* - This leads to slow rise of plasma progesterone, reflecting on the BBT chart as a step ladde pattern or a typically slow temperature rise at midcycle. Higher doses of HCG (5000-10000 i.u.) given to supplemen the LH Surge and trigger ovulation. with an additional doses o 2000 i.u. HCG on 4th and 7th day of luteal phase will suppor luteal function.

A ? LH SURGE



12. **Summary :**

(i) The ovulatory cervical mucus is an inbuilt indicator of woman's fertility, scientific and reliable, easily recognised by women to pinpoint ovulation, and thus adjust the time o coitus for better results of conception.

ii) The Cervical mucus score is very useful to assess the positive role of mucus in fertility.

iii) Post-coital test of the cervical mucus is also a useful means of assessing sperm-mucus penetration, cervical hostility, or presence of sperm antibodies.

iv) BBT in turn is a good and reliable indicator of the occurence of ovulation, with its biphasic pattern. It also reflects various abnormalities of ovulation like follicular phase defects, abnormal LH Surge and luteal phase defects. Besides compared to recent sophisticated tests available, this is a simple and easy means for monitoring the treatment cycles while treating ovulatory problems in infertility.

SOME OBSERVATIONS ON TEACHING NATURAL FAMILY PLANNING

Dr. Dara Amar M.D., Professor & Head Department of Community Medicine, St. John's Medical College Hospital

The following observations have been made during the course of the various training programmes conducted in teaching Natural Family Planning (NFP).

(1) Quoting and discussing actual case histories of couples with specific problems has proved to be a method better than others, of convincing people regarding the importance and acceptability of NFP.

(2) Contrary to what we might like to believe, it was found that the majority of the trainees in the Indian context are convinced about the effectiveness of NFP, only if facts and figures of acceptance and effectiveness are given. Appealing to reason and emotion appears to play a secondary role in acceptance.

(3) Teaching NFP through role plays, using experienced teachers, is highly acceptable, and the audiences appear to identify themselves more readily with either the teacher or the taught in the role play.

(4) Trainees are more responsive to NFP, if it is discussed in comparison with other family welfare methods.

(5) A discussion of socio-political factors related to the acceptance of NFP is often asked for by professional trainees.

(6) Inevitably, certain important aspects of NFP need to be emphasised, only in the local languages, if they are to be understood clearly.

(7) In the formation of groups for group workshops in teaching NFP, it must be remembered that the participants prefer to form groups using the local language, and more importantly, they feel each region has its own peculiar set of circumstances while advocating NFP.

(8) Use of indigenous materials/techniques for charting etc. is very important. Imported glossy charts and stickers are considered to be too good or too costly for routine use.

(9) Generally, medical doctors were found to be the most difficult group to convince regarding using NFP methods. Even after accepting the facts and figures of NFP, they still feel hesitant to accept the fact that it is possible for a woman to feel her "wetness" in order to ascertain her fertile period, without confusing herself about leucorrhoea etc.

(10) The strongest reason for Doctors' hesitancy in teaching NFP appeared to be that they confuse the Cervical Mucus Method with the Calendar Method. Surprisingly, there was no such confusion with non-medical groups. This perhaps is a reflection on the quality of the teaching of family planning methods during the undergraduate medical career.

(11) For the purpose of initial exposure to the Cervical Mucus Method, it was noticed that, at one time, NFP orientation seminars were very popular. This was a necessary first step to generating interest in the later detailed training programmes in NFP.

(12) There was a great demand for knowing and adopting innovative methods of health education, which could be used for teaching NFP. Widespread interest was especially shown in methods involving story-telling to make lay people understand the menstrual cycle, and thereafter, the Cervical Mucus Method. There was confusion in the use of local terminologies for the various parts of the female reproductive system. While there were clear-cut terms for the uterus and the vagina, no specific terminologies exist for defining the cervix.

(13) At the end of each session, a special seminar used to be organised on action planning for the propagation of NFP. However, the participants themselves could not take concrete decisions regarding future plans, since many of the decision factors were controlled by heads of the organisations, who were content to send only their subordinates for these training programmes.

(14) Although fixed syllabi for training must be prepared before each session, it was found that the expectations of the course, as expressed by the trainees, were often not present in some of the standardised NFP syllabi available. It was, therefore, important for the trainees to be asked about the expectations of the course, after they were shown what the Billings Method is about.

(15) It is to be noted that the main principle of the Billings Method must be explained briefly in the beginning itself. This is to assist trainees to connect the various features of the menstrual cycle, reproductive anatomy, physiology etc. with the actual Cervical Mucus Method. Failure to do so inevitably makes the participants wonder why, at the sfart of the training kprogreamme, they must know about the menstrual cycle etc. and what connection this has to the Cervical Mucus Method.

(16) Although training persons in NFP at the peripheral grassroot level is important, it appears that people tend to accept the method, only if large institutions recognise and propagate the Cervical Mucus Method. It is, therefore, important for large teaching institutions and hospitals to be included in the training of NFP teachers

(17) At the end of the training programme, it was noticed that, in order to emphasise the main features of the Cervical Mucus Method the participants must be asked to come forward and teach the rest of the group in the local language, and use subjects and environments like alcoholic husbands, predominantly male audiences, slum areas etc. The efficacy of the training is ultimately judged by the manner in which the participants teach, and how many mistakes they make in the teaching of the Cervical Mucus Method. The mistakes need to be immediately corrected. This last "summing up" is important in securing a lasting acceptance by the trainees, of the Cervical Mucus Method as an effective method.

The participants about whom the above observations were made included highly qualified obstetricians, graduate-level doctors, medical college teachers, medical students, nursing students, nursing personnel, social workers, school teachers and a large number of lay housewives and husbands. The observations accordingly reflect a fairly wide cross-section of potential NFP teachers and users in the country involved in training programmes conducted in Srinagar in the north, Bombay in the west, Kottayam and Bangalore in the south and Calcutta in the east.

"FERTILITY AWARENESS AND ITS USE - AN ENTRY POINT ON WOMEN'S DEVELOPMENT."

Dr.Kathleen Dorairaj, Executive Director/Consultant, Natural Family Planning Association of India, New Delhi.

1. In India, fertility awareness, education and natural family planning services and programmes are short term time bound activities of non-government organizations based on the motives of the promoters and availability of resources. Since 1977-78 Natural Family Planning (NFP) services of relative intensities have been implemented through non-government agencies financially supported by 2 projects of Misereor through the Indo-German Social Service Society, New Delhi. The first three year project with 61 participating programmes was a demonstration type pilot programmme, as here was no earlier experience for implementing a large spread-out formal intensive NFP project with participating centres in India. Action, Research and Training, supported by the Swiss Development Corporation for non-Catholic organisations have been directed to train leaders and decision-makers of non-government groups which are non-Catholic and with a follow-up action in about 20 NGOS.

2. The availability of a range of NFP methods and strategies designed and tested in the field to reach poor women through service programmes, and 3 action research projects have developed NFP from a religious and moral philosophy to a tool of women's health, and of development and community participation for poor women. Women's health is a concept that encompasses the total concept of health, -physical, social and psychological, and is a tool or facilitator of women's development.

3. The linkages between fertility awareness, education and NFP, with women's development are at two levels : (1) Directly at the programme level, i.e., programme strategy related to women's development (2) Indirectly related to the level of the individual woman. This paper deals with the empirically based linkages between the fertility awareness education and NFP.

4. **Sources of data :**

   Users of cervical mucus method in north and central parts of India ; there were 30 pilot studies. The linkage studies followed by the variable studies were :

   1) Acceptance rates
   2) Continuation rates
   3) Use effectiveness rates
   4) Demand for NFP
   5) Psycho-social variables related to acceptance and use
   6) Mobilization of women
   7) Community participation of women

5. **Acceptance rate :** This is the percentage of total number of married women of reproduction age in a community who are prepared to use NFP on instruction or contact. i.e., registered acceptors. Method effectiveness study and use effectiveness cannot predict the acceptance rate, neither can knowledge, attitude and practice surveys.

6. **Reasons for non-users of NFP** (younger women mainly)

   a) No living child
   b) Plans to get pregnant

c) Perceived difficulty in using the method
d) Higher frequency of sex.

NFP acceptance was low in the poor class because of non-compliance by men. NFP method promoted was a NFP innovation, modified to suit the needs of the poor with a shorter period of sex abstinence, and phased teaching with support from the local staff.

7. **Continuation rate :** The continuation rate was also seen to be high as compared to 91% in the earlier study.

8. The use effectiveness rate was 94%. It was seen that poor women could control fertility effectively. using NFP innovation if it is accessible to them.

9. In India, it was found that more demonstration projects were required for teaching NFP, preferably district-wise. The level of motivation was NFP was low. inclination for the use of the intra-uterine device (IUD) was higher. Use of condom by the husband also showed a higher preference. Other variables like education, status of husband and wife, their occupation and duration of marriage, seem to effect NFP. Intra-spouse co munication was more among those who are using IUD an condom. There was a lower intra-spouse communicatio among those who had exceeded family sizes and those w underwent sterilization. The fear of pregnancy and husba dominance also inhibited the use of NFP. If the higher leve husband's motivation towards NFP showed better intra spouse communication. In India the husbands have not be very motivated in NFP learning.

10 The programme strategies and development at 3 levels :

a) Initial provider at taluk level

b) NFP instructors-village cluster level- with a women village leaders.

c) Users that involve local women's group, and involveme of women in the local community, their participation in solving all their problems helps in promoting NFP and turn, education in NFP being given through the instructor the community.

DEVELOPMENT OF NATURAL FAMILY PLANNING IN THE 21ST CENTURY : CHALLENGE OF DEVELOPING QUALITY NFP SERVICES

Claude A. Lanctot, M.D., FRCS, FACOG, MPH, Executive Director, International Federation for Family Life Promotion (IFFLP)

Introduction

1. During the last 25 years, especially since the establishment of international associations for the promotion of Natural Family Planning in the early 1970's, the sound scientific basis, the very acceptable effectiveness rates of natural methods, have been clearly established in repeated studies. This validation of NFP as a family planning option has been fairly well established in some major family planning policies, both at the national and international levels. This is reflected by the willingness of several governments to encourage some support of natural family planning development, and by UN agencies such as the WHO, supporting some of its research and development efforts, and by UNFPA including NFP in its revised informed choice policy section of the World Population Plan of Action at the 1984 Mexico Population Conference. However, the effective, or readily available, choice of NFP services in the family planning world on an international basis remains in our opinion, fairly limited, if not restricted.

2. **State of the Art**

   There are several major areas where important contributions were made in the field of Natural Family Planning.

3. The confirmation of the reliability of effectiveness of natural family planning methods was a major accomplishment of the recent period.

4. **The Fairfield Study by Rice *et al* (1981) :** This is one of the collaborative pioneer prospective studies on the STM (Sympto-Thermal Method) which was conducted with established NFP programs in five countries from 1970 to 1973. It recruited 1022 users, and followed a meticulous protocol of registration and follow-up, carefully documenting the follow-up of 20,573 cycles, and of all the pregnancies, in order to identify precisely all the 128 unplanned pregnancies. It clearly established that, differently from calendar rhythm, the regularity of cycles was not an important factor in selection or success, as 80% of the participants presented cycle variations of more than eight days.

5. **The Multi-centre U.S. Study by Klaus (1979)** : This study conducted between 1972-1977 followed 1090 users from six centres for some 12,283 cycles over a two-year period. Although the cumulative method failure rate was low at 1.17 pregnancies per 100 woman-years, the correct computation of all unplanned pregnancies due to a couple's departure from the rules, as "users" - related pregnancies, provided a cumulative "user-effectiveness rate" of 19.25.

6. **The WHO International Collaborative Study of the Ovulation Method :** This was undertaken in five countries, El Salvador, India, Ireland, New Zealand and the Philippines, between 1975-80. The initial learning phase of three months dem-

onstrated that more than 93% of the registered women recorded an interpretable mucus pattern. Only 1.3% failed to learn how to interpret changes in their cervical mucus.

7. **The NFP Programme Evaluation study in Liberia and Zambia - Retrospective Analysis of Autonomous NFP Users :** Recently, the Johns Hopkins University team published two studies on the very important phenomenon of the Autonomy in NFP Users (Kambic and Martin 1988 and Kambic *et al* 1990)

NFP CLIENT LEARNING MODEL

Information (Outreach)	Learning	Autonomy
Registration	1st Follow-up (Acceptor)	Variable Program Definitions of Autonomy
Avoider Achiever		

Technical Autonomy

8. NFP autonomy is operationally defined as being the state reached when the learning NFP user couples are able to :

   (i) chart correctly daily fertility indicators;
   (ii) understand the fertile and infertile days of their cycle including the ability to recognise a change in fertility patterns and to seek help when needed;
   (iii) adjust sexual behaviour with their spouse or partner to correspond with family planning intention. i.e., use periodic abstinence if pregnancy is not desired;
   (iv) express satisfaction with the method.

Leading the NFP learning to autonomy is central to understa ing the demands of an NFP service as well as understanding dynamics of an NFP service program that has reached a cert maturity. This simplified or schematic model of a theoretic NFP client service allows that establishment of a clear und standing of what is at the core of an NFP educational servi along with the importance of autonomy.

9. **Biochemical Indices of Potential Fertility :**
Given the prominence of biochemistry and endocrinology a the basic sciences for a medical approach to fertility, it is n surprising that major research efforts have been geared ov the last 15 to 20 years to a variety of methods for determini the fertile period. This area of research was encouraged b WHO (1983) and periodically reviewed by such authors as Collins (1981, 1989), Flynn (1989) and Brown (1989).

10. **Development Aspects of Natural Family Planning Service**
Over these last 15 to 20 years, with the progressive growth technical assistance for NFP program development, a varie of issues have arisen such as -

- the training of NFP teachers;
- the recruitment teaching and follow-up of users ;
- the development of program evaluation and accountability
- the development of program standards;
- the questions of costs and cost-effectiveness;
- whether or not NFP as a Family Planning option should b integrated within national family life programs.

11. **Training of NFP Teachers :** since the active component in NFP is periodic abstinence during the fertile period for those users who wish to avoid or postpone a pregnancy, the quality of the teacher-learning-user relationship is central to a quality

NFP program. Most of the established NFP programs have their own training manual, and in the late 1970s (1976-80), WHO developed its own educational handbook and Family Fertility Resource (Learning) package, following a systematic questionnaire survey of some 30 national training programs. It was updated as a second edition in 1985 after field testing in six countries, and translations into both French and Spanish were made available in 1989. The IFFLP recently completed a revised edition of a Multiple Choice Questionnaire for the evaluation of NFP teachers, and this can be used as an important complement of the WHO Resource Package. An English and French edition of this evaluation are available.

12. **The Equipment, Teaching and Follow-up of NFP Users :** This is the key to an NFP service, with achievement of user autonomy as the primary goal of the service. Since a majority of NFP services are still primarily at a movement stage, or are largely made up of volunteers, this is often an area requiring special development efforts.

13. **NFP Program Evaluation and Accountability :** This can be approached in a very discipline manner under its four major areas described by Gray and Kambic in the IFFLP/NFP program development monograph (1984).

14. **Miscellaneous Aspects of NFP Development :** Five additional areas of NFP development have consciously been left out of this brief overview :

    (i) The major advances in our better understanding of the changes in cervical mucus in the ovulation method as the major index of fertility, from the work of Odeblad (1978), and the indirect major mediator role of ovarian estradiol in the physiology of the fertile period, recently elucidated by Burger (1989).

    (ii) The rediscovery of the importance of breast-feeding or lactational infertility as the major traditional approach to the natural regulation of fertility, with the recent contributions in this area by Family Health International (FHI) and Thapa (1988) as well as those mentioned in the Bellagio Consensus Statement.

    (iii) The slowly unfolding documentation of the outcome of NFP pregnancies to better understand the actual extent of the risk of aging gametes in humans. This was recently reviewed by Kambic, Gray and Simpson (1989) who analysed both the contradictory evidence from the literature, and the status of the current on-going prospective study of pregnancies users at the University of Tennessee and the Johns Hopkins University.

    (iv) The Modified Mucus Method pioneered in India by Dr.K.Dorairaj (1988).

    (v) Initial pilot studies in India, Nepal and several African countries indicate promising levels of acceptability and use-effectiveness which will need to be further confirmed.

15. Here are but a few reasons why NFP service must be developed as a valid and quality alternative family planning option :

    (i) NFP is potentially a use-effective and cost-effective scientific method as the growing evidence presented here substantiates;

    (ii) NFP is both ecologically and humanistically sound, and does not interfere with the basic physiology of reproduction; on the contrary - it seeks to enrich the users with a functional

fertility awareness education which allows both spouses to work as a couple to integrate their human fertility potential with their love-making and family planning objectives. It is, therefore, innocuous and potentially promotes conjugal communication which relieves couples from dependence on contraceptive supplies or a medical system which is often non-existent, over-burdened, or increasingly too expensive

(iii) NFP is acceptable to a substantial number of couples from many cultures and religions. The example of Mauritius is pertinent where in a small island with a multicultural community, the NFP option has now been offered for more than 25 years and the proportion of family planning users opting for it is over 20%.

(iv) In the long run, the cost-effectiveness of including NFP in the family planning services options, is probably comparable to if not better than many other contraceptive options, for which the cost of treating secondary complications or of maintaining continued supplies for the reversible ones, has to be taken into account.

16. Basics of NFP Service Development

In the remaining section of this paper, some of the key questions which need to be answered in NFP service development will be touched upon:-

1. *The process of NFP Service Development :*

The field experience of the IFFLP over the last 25 years has surfaced the importance of recognising three general stages or phases of service program development, each with its own varying strategies and goals. These can be identified as :

(i) *Initial or Implantation Stage :* This covers the first three or more years, during which an NFP group begins to work to identify its priorities and objectives. It involves establishing NFP services in terms of training a corps of teachers, providing them with teaching materials and instituting effective management procedures. The budget initially is usually minimal.

(ii) *Demonstration Stage* This critical stage that is too often short-circuited by many programs, is when a core team begins to structure and develop a functioning NFP service system with components of administration, training and supervision of NFP teachers and delivery of NFP services

(iii) *Expansion Stage :* At some point between five and fifteen years, depending on the success of the demonstration phase and the acceptance of NFP services by the population, many of the service delivery systems will need to be expanded

2. *Training and Supervision of NFP Teachers :*

This has been and will remain one of the central activities of an NFP program, although it can and does sometimes become specialized at a central or regional level of a country with the creation of national or regional NFP teacher teams or group of trainers The key role of the NFP teacher is to present NFP in a proper inculturated fashion to the clients: the teacher has to be cognizant of their culture, religion, degree of literacy, etc. A great deal could be discussed about the commitment to and patterns of learning of the NFP user, from registration to autonomy, either as a specialized

NFP service, or. as is frequently the case, integrated with other health education, or with a religious program. The culturally appropriate NFP teaching role can be conceptualized as helping the user-couple in

(a) Learning to use NFP;
(b) Learning to live with NFP;
(c) Learning to Love with NFP

3. *Program expansion :*

This will no doubt be a major role for NFP programs in the 21st century. Here below are a few concluding thoughts on the experiences of NFP service integration and on program sustainability.

(a) *NFP Service Integration*

This can be defined as the process by which NFP services are introduced into a new context or service system which can bear part of if not all, the costs of this new service dimension, if successful. Here are a few elementary steps for the integration of NFP into other service systems:

(i) The recruitment of professional staff or workers (health educators, community workers and others) as teacher trainees, with a joint comitment by the trainee and his superior that the NFP service can become part of their job description;

(ii) Identification of various potential service sites, e.g., dispensaries, hospital clinics, community or women centres, MCH, vaccination, or even family planning clinics where they would welcome an NFP teacher to begin to offer NFP services once or twice a week.

(iii) Exploration of setting-up an NFP demonstration service within a Church setting or a factory for its female workers or families or a health centre,hospital, etc.;

(iv) Discuss some of these alternative scenarios with donor agencies or advisors

17. It is the firm conviction of the author that careful attention to the selection of the proper partners. strategies and scenarios is often critical for the success of integration. This process is also a way to grow without having to completely support all the new costs. It is an approach which may be especially promising in India, where many existing service NGO's could be interested in offering NFP if it is introduced correctly (i.e. with due regard to their own service ethos).

18. **NFP Program Sustainability :**

Sustainability can be perceived as the opposite of vulnerability and dependency. It is the capacity of a service program to progressively achieve self-sufficiency, or at least greater stability of resources derived from a diversity of funding sources. The agenda towards the sustainability of NFP services will take us well into the 21st Century and we have much to learn in this area from other successful NFO's in our own respective communities.

19. **Conclusions :**

It is clear from this vast and ambitious agenda for NFP service development that many NFP programs will soon need compe-

tent managers in the 21st century. It is part of the program of the Federation (IFFLP) to increasingly address itself to this need by the continued organisation of management-training workshops preceptorships and consultancies. My final wish is, that following the long experience of NFP service development in India, we might see the day when NFP services and fertility awareness education will be included within the family planning policy of the Ministry of Health, and that both private and public donor agencies will become increasingly interested in supporting the development and integration efforts of NFP services in India.

"Lord, it was you who created my inmost self
and put me together in my mother's womb.
For all these mysteries, I thank you
For the wonder of myself, for the wonder of your work
You know me through and through
from having watched my bones take shape
when I was being formed in secret
knitted together in the limbo of the womb"

- Psalm 139 : 13-15

WELFARE OF WOMEN AND FAMILY PLANNING - AN ASIAN PERSPECTIVE

Dr. (Sr.) Catherine Bernard, Secretary and Executive Director, Service and Research Foundation of Asia for Family and Culture (SRFAFC)

1. Introduction

The subject of this paper is much too vast, and the theme too complex to be covered in a single presentation. However, it is hoped that this paper will stimulate further efforts to enable the potent community of women in Asia, to work in total partnership with all persons of goodwill, in cooperation with men and women of other groups, to bring new vitality and full strength to the families of Asia.

2. Contemporary human situation in Asia

Asia is not only the most populous region of our planet with almost two-thirds of its humanity, but also the home of about 75% of its poor. Its millions of women, undernourished children, unemployed youth, situations of oppression jointly brought about by internal and external forces, its growing disparity in economic conditions coupled with serious injustices, gross violation of human rights and human dignity, indicate that dehumanising systems are not only increasingly becoming wide spread, but also intensified and diversified at various levels. Within this existential situation, the number of poor, despite all welfare programmes and industrialisation drives, has steadily increased, while the capacity of the people to buy even the commodities essential for basic human living has, at the same time, rapidly diminished in the past two decades. It is against this global background and perspective that one needs to understand birth control and population policies with specific focus on Family planning and the Welfare of women in Asia.

3. Family planning programmes in Asia, and for that matter, in all third world countries, are not isolated or form individual programmes. They form part of the complex system of serious injustices which are consequent upon many factors - social, political, economic and cultural, operating and interacting at different levels: global, national, regional and local.

I. Some Major Problems and Their Inter-relatedness affecting the women in Asia

1. Millions of women and female children the world over are the victims of various forms of violence and pull-and-push factors that operate at domestic, local, national and international levels. Some of these problems are :

   (i) *Battered women :* In most countries in Asia, both rural and urban women from all social strata are threatened by this form of violence.

   (ii) Alongside the growth of prostitution is the increasing regular traffic of young women and children, not only into local/national sex markets, but also into the overseas sex indus try.

2. In November 1988, at an Asian Consultation on Prostitute Women and Concerned Activists was held in the Philippines, the following were some of the conclusions arrived at:

   (i) Close relationship between prostitution and milita-

rism; militarism contributes to the growth of prostitution (Philippines, Japan and Korea).

(ii) Poverty and prostitution are closely interlinked issues (Malaysia, Philippines, India, Sri Lanka, Indonesia).

(iii) Prostitution and migration, particularly in Asia are an inter-related phenomenon impinging upon each other in various ways.

(iv) Various social systems contribute significantly in India, the caste system; in Korea, the preference for sons; in Malaysia, liberty for men to go to Thailand for weekend sexual encounters; in Japan, organised sex tours, and sex tourism.

(v) Colonialism and its cultures, e.g. racist superiority that stemmed from it in significant instances, have exploited women, especially through institutionalised religion, while at the same time, imposing strict codes of morality on women - as in the Philippines, India, Korea, Sri Lanka and Indonesia.

Alongside these major and complex problems and issues, the selective elimination of female foetuses is widely practised in several Asian countries. Several surveys have proved that today, in several parts of India, female infanticide is practised even by people who are well off. Some of the caste sub-division play an important role in maintaining these savage traditions, which result in an imbalance of the sex ratio. Indulging in vicious commercialism, the cinema industry promotes male chauvanist values. It encourages sexual exploitation of women. Many social evils such as the dowry system and bride-burning have assumed monstrou proportions.

3. It is against this Asian reality that authentic and humanisin family planning programmes, with emphasis on education women, will help women in Asia to recover their identity an assume their proper role in an ever-changing technologica society.

II Welfare Measures and Programmes undertaken in Asia t alleviate the problems affecting women

1. In the countries visited last spring, it was noted that, in addition to the provision that has been made for information counselling, as well as for temporary housing for women an female child victims, special emphasis has to be laid all ove the continent, on rural women, women workers, youth an potential victims of forced prostitution and of domestic violence. Experience indicated that these services are also needed by women who are better off, especially in the matter of domestic violence.

2. Educational programmes in the various countries have shown, that women need training, not only aimed at economic improvement, but also for creating consciousness to help one another in their problems, and to get organised, for collective action.

III Beyond Welfare Measures - i.e. Towards the wholeness of the person

1. Taking a look at our Asian cultures and heritages, we note that they are inspired by a vision of unity. The universe is perceived as an organic whole, while relationships are like

a web, knitting together each and every part of it. In Asian cultures, nature and the human person are viewed as realities held together in unity through a universal rhythm. This unity is reflected in human consciousness and spirit, which merge together into a wholeness and harmony. This is the eastern concept of wholeness and harmony by which total well-being of the human person is secured.

2. A second characteristic of the orient is "going inward" - the person is initiated into becoming aware of the spirit by inner experience - reaching the core where expectations and desires arising from his very being are inseparable from his innermost self. It is through this insight that the person achieves his identity and perceives reality, not merely by "knowing" but by actual "experiencing".

3. Asia is a land of impulses, and therefore, a third characteristic of the people of the orient is their spontaneity. For us orientals, worship of God is not a "duty". The sense of the Divine and the Religious is an instinct, a longing, a passion.

4. A fourth characteristic of Asian peoples is readiness to renounce all material things, and accept poverty, homelessness, simplicity. This has been experienced in the life of Buddha, Mohammed and the Bakhti saints of Hinduism, and the spiritual leaders of Jainism and Sikhism. Christians have their model in Jesus Christ.

IV Family Planning and Womanhood/Personhood in Asia

Thus in the entire task of promoting the well-being of women in Asia, both women and men have important roles to play in transforming the social position of women. However, women have to be the prime-movers of this change.

Conclusion

1. As a woman of the Indian soil, and in the name of the millions of women and families in Asia, both known and unknown, whom I have met and have yet to meet, and in whose lives I have had a part, I earnestly appeal to those engaged in the various Family Planning Programmes - local, national and international, Church and voluntary agencies, and the governments - to invest adequate financial and human resources in Scientific Natural Family Planning and other family oriented programmes. It is the only way that contributes to the all-round well-being of men, women and the family. At the same time, I call upon multi-national corporations, pharmaceutical companies and Governments to resist every form of coercion, manipulation, cultural negation and violation, and to stop every form of imperial domination, especially over the poor of the third world countries, by the use of invasive means of contraception and birth control.

2. In this yatra-pilgrimage of the Asian people, I conclude with the words of the pilgrim song :-

Asato ma sad gamaya	From the unreal, lead us to the real
Tamaso ma Jyoti Gamaya	From darkness, lead us to light
Mrityor ma Amritham gamaya	From death, lead us to immortality
Om Shanti, Shanti, Shanti	Peace, Peace, Peace to all.

ECOLOGICAL BREASTFEEDING AND CHILD SPACING

Robert L. Jackson, MD

Until the 2nd and 3rd decades of this century, breastfeeding was essential for infant survival. In that period, spacing of children was generally about 2 years. Later, improved modified cow's milk preparations became commercially available and were well tolerated by most infants. As a result, near cessation of ecological breastfeeding occurred toward the middle of the century. The decline in ecological breastfeeding was associated with early postpartum ovulation and shortened child-spacing of about 1 year.

The endocrinology of breastfeeding is now known in considerable detail. Prolactin is secreted promptly in response to nipple stimulation and is a reliable marker of the endocrine alterations occurring postpartum. Success of lactation in suppression of ovulation was found to occur when infants sucked frequently and when only small amounts of selected foods were introduced gradually after the infants were about 6 months of age.

DEMOGRAPHIC DATA was recorded prior to the 20th century from birth records all over the world indicate that the average spacing of children was about 2 years when mother's milk supplied the major source of calories for infants during the first year to 1.5 years of life.

In the 2nd and 3rd decades of the present century, artificial feeding gradually became possible because of advances in technology in many areas, including simple methods for modifying cow's milk, development of sanitary methods for handling, refrigerating and distributing cow's milk, understanding of the need for vitamin supplementation, and the development of improved rubber nipples and nursing bottles.

Toward the middle of this century there was a cessation of breast feeding but there has been a gradual return to it, especially among upper socioeconomic groups, in the 1970s and 1980s. Until the 1920s, most infants who thrived were nursed on demand and seldom were fed other foods before 10 to 12 months of age. By 1937 most pediatricians were advocating the introduction of semisolid foods for both bottlefed and breastfed infants by 2 to 4 months of age. Iron fortified foods and sieved fruits an vegetables were felt to be necessary to prevent iron deficienc anemia and constipation in bottle fed infants.

Ecological breastfeeding consists of: 1) feeding only human mil for about 6 months; 2) suckling on demand day and night; 3) n pacifiers; 4) gradual introduction of small amounts of selecte foods at about 6 months; and 5) continuation of nursing as th primary food for about 1 year or longer.

In western countries, most mothers were advised to breastfeed their infants only five to seven times a day and to offe supplementary bottle feedings when the baby demanded more food than she could readily supply. Consequently, the mother's milk output decreased, requiring additional supplementary feedings that resulted in a cascade response, with a gradua replacement of breast to bottle feeding over varying period o weeks or months. This type of breastfeeding is not ecological.

Human milk from well-nourished mothers is now known to meet the nutritional needs of "well-born" babies for about the first half-

year of postnatal life. The weaning process is naturally a lengthy one (months, not days or weeks), and the gradual introduction of selected foods need not inhibit a mother's ability to lactate and continue to supply the major source of protein and other essential nutrients and calories. How long breastfeeding should be recommended depends on many factors: sociologic, economic, physiologic, and psychological. There are justifiable reasons to encourage mothers to breastfeed their infants the first year of postnatal life. There also are extensive, scientific data to document that for optimal nutrition, infants require other selected foods in the second half year of postnatal life.

The rapid decline in ecological breastfeeding from 1930 to 1960 resulted in early postpartum ovulation and in shortened child spacing of about 1 year. In other words, fertile women who adopted bottle feeding to their infants as advocated by health professionals lost the prolonged natural period of infertility of about 1 year associated with ecological breastfeeding.

Endocrinological Basis of Lactational Infertility

The ovulative suppressant effect of ecological breastfeeding with consequent lactation-amenorrhea is now well recognized, and we now better understand the endocrinological basis for this phenomenon. Prolactin, a pituitary hormone, has been found to be associated with the suppression of ovulation and may be directly responsible for ovarian suppression. Postpartum plasma prolactin levels differ greatly in nursing and non-nursing mothers. The secretion of prolactin has been shown to vary quantitatively with the sucking stimulus to the breast.

In practical terms, this varies with the number of feedings, their length of time, and the vigor of the baby. Use of pacifiers or anything that blunts the infant's suckling diminishes prolactin secretion. In addition, sucking reduces the normal pulsatile release of gondatropins [follicle stimulating hormone (FSH) and luteinizing hormone (LH) by interferring with the normal peaks of gonadatropin-releasing hormone (GnRH) from hypothalamus. Whatever may be the exact mechanism of lactational-amenorrhea, prolactin has been found to be useful and reliable marker of the endocrine alternations occurring postpartum.

Endocrinological alterations also result in changes in postpartum mothers that foster bonding with their infants. After a natural delivery, a new born baby is very alert and responsive. Recent studies indicate that the baby should make immediate tactile contact with the mother after birth and nursing should occur as soon as possible. Oxytocin not only stimulates uterine contractions during labour but also has an other important function in initiating and maintaining lactation. After birth, oxytocin secretion is stimulated by various sensory stimuli such as hearing the baby cry, cuddling the baby, and by the baby rooting for the nipple. Oxytocin acts on the myoepithelial cells in the breast to eject or "let down" the milk. The natural release of this hormone precedes suckling, (before suckling, most newborn infants stimulate the nipple by licking or nuzzling it. Within hours after delivery there is a sharp rise in the sensitivity of the nerve endings to the sucking stimulus, which ensures there is a rapid firing of neurological impulses to the brain. It is for these reasons that newborn infants should remain in close contact with their mothers.

Since 1950, we have had evidence by serial postpartum basal temperature recordings and by histological examination of endometrial biopsies (during periods of lactation-amenorrhea) that breastfeeding does suppress ovulation. The success of lactation in suppressing ovulation occurs when the baby sucks frequently (both day and night) without supplementary bottle feedings or relatively large servings of semisolid foods. Thus, the

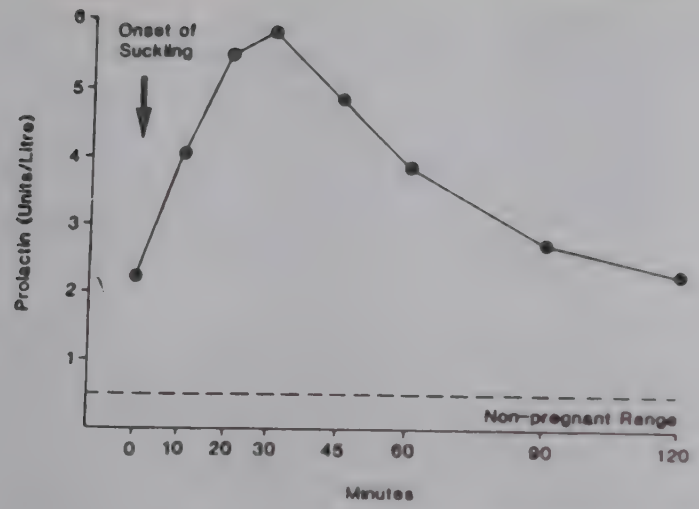


FIG 1 Prolactin response to nipple stimulation (day 5). (With permission Adapted from Howie P J Clin Endocrinal Metab 1980, 50:670-2.)

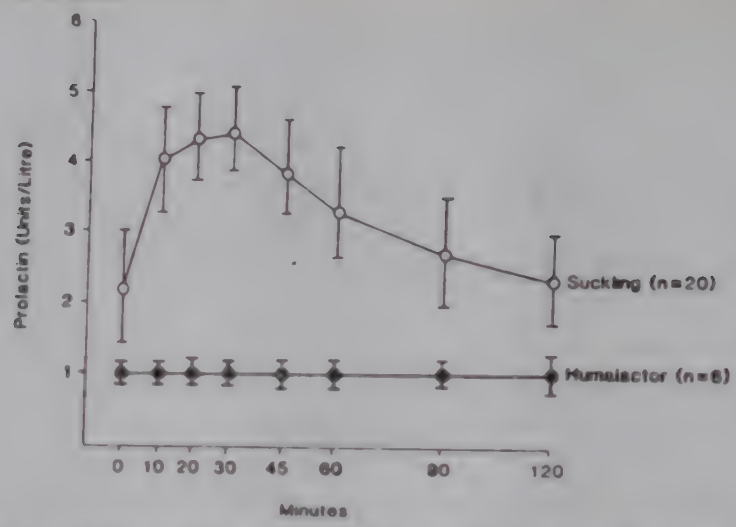


FIG 2 Prolactin levels in response to sucling and to artificial breast pump.(with permission Adapted from Howie P J Clin Endocrinal Metab 1980,50:670-2.)

duration of infertility associated with lactation is greatly reduced if breastfeeding is partial, token, or supplemented early introduction of excessive amounts of semisolids.

In a well-controlled study in Edinburgh, a suckling frequency of more than five times and more than 65 minutes minimum (10 min/feed) each day was found sufficient in that population and culture to maintain suppression of ovarian activity. As depicted in Figure 1, prolactin is promptly secreted in response to nipple stimulation, increasing two to 20 folds in plasma during 5 to 15 minutes of mechanical stimulation of the nipple with a half life in the plasma of 10-30 minutes. Figure 2 indicates that prolactin is absent when an equal amount of milk is produced by pumping the breast.

Nursing women maintain a higher prolactin level and lower gonadal hormone or gonadotropin level postpartum than do non-nursing women. Prolactin levels decline more slowly in women who nurse more than six times a day than in those who nurse less frequently. The decline in nursing frequency and level of serum prolactin and the recovery of gonadal and gonotrophic hormones occur in concert.

The amount of prolactin released with suckling in the afternoon and night hours is greater than in the morning (fig 3). A diurnal variation in prolactin secretion also has been observed in non-lactating women.

The duration of amenorrhea then is related closely both to maintaining the night feedings and to maintaining an adequate production of milk to meet the nutritional requirements of the infant for optimal growth. These studies confirm that ecological breastfeeding, even in industrialized countries with well-nourished mothers, suppress fertility for a considerable period to time.

Decrease in suckling was found to occur with early introduction of

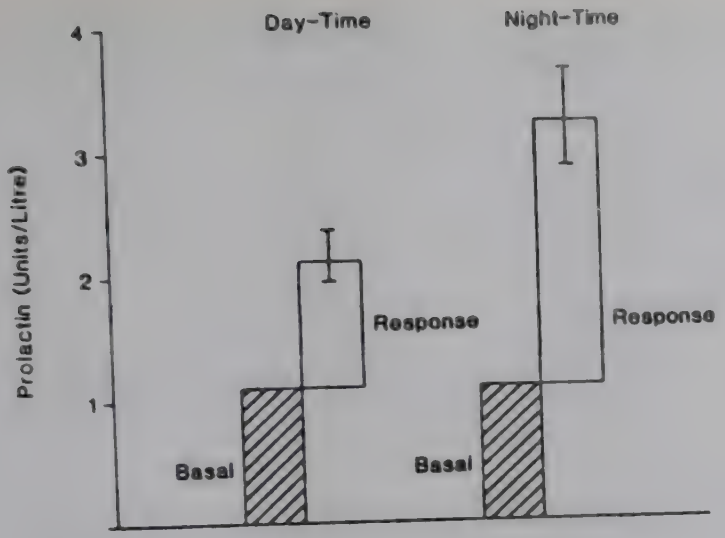


FIG.3 Variation in proactin response to day and night time feedings

supplementary foods especially when given in the late evening to prolong the period between feedings during the night. Rapid reduction in suckling or weaning, especially if occurring after prolonged lactation, often results in prompt ovulation with normal lacteal function and conception when the mother was only partially nursing the baby. Figure 4 compares the infant feeding patterns of three groups of mothers on the basis of the time period to first ovulation. Group 1,those who did not ovulate until after more than 40 weeks : Group 2, those who ovulated between 30 to 40 weeks; and Group 3, those who ovulated before 30 weeks postpartum. The mean total duration of breastfeeding was 53.3 weeks (+- 5.8 S.E.) for nine mothers in Group 1, compared to 37.3 (+- 2.4 S.E.) for nine mothers in Group 2, and 24.4(+-5.6 S.E.) for seven mothers in Group 3.

Figure 5 compares the prolactin levels (PRL) in the three groups of mothers. The PRL levels had fallen to the non-pregnant range

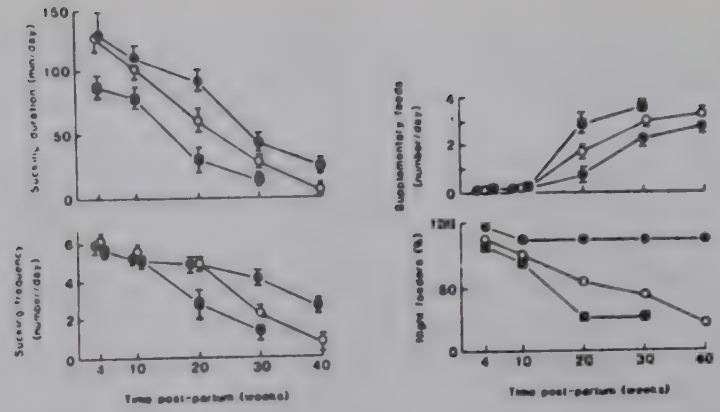


FIG.4. Comparison of suckling duration (mean + - SE), suckling freequency (mean +/-SE), supplementary feeds and number of night feeders in mothers who ovulated in the late (> 40 weeks,), middle (30 - 40 weeks), or early (< 30 weks) post-partum period.

at 20 weeks in the early group and at 40 weeks in the late group.

Resumption of Fertility

Fertility can return prior to the renewal of menstruation. women who reduce the frequency of breastfeeds slowly by gradually

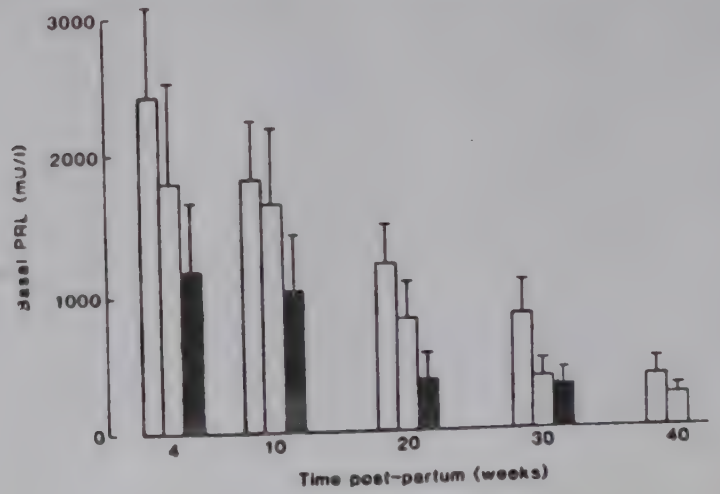


FIG 5. Comparison of basal PRL levels

introducing only small servings of other foods over a period of months are likely to have one or two infertile menstrual cycles.

In a group of breastfeeding women in Chile, not using contraceptives and not known to be giving their infants supplementary bottle feedings. Diaz found that about half of them ovulated before their first menstrual period. He also found that the probability of pregnancy was about 2 percent for those who had not resumed menstruation and 25 percent for those who had. The association between the giving of food supplements to the babies and the duration of amenorrhea was confirmed by this study While 49 percent of the women considered to be ecologically nursing their babies remained in amenorrhea at the end of the sixth postpartum month, only 19 percent of those who gave supplementary feedings had not menstruated. In the prospective studies of Howie et al., they found that menses and possible ovulation returned much earlier during partial breastfeeding as compared to ecological breastfeeding, and none of the women ovulated while they continued to nurse without giving supplements (Figs 4 & 5).

A recent study by Perez *et al.* demonstrated that the chances of ecologically nursing mothers ovulating in the first 10 weeks postpartum were practically nil and from the 11th to 24th week months) were less than 5 percent. Based on ultrasound a hormone studies. Flynn found that in fully breastfeedi mothers, ovulation is often delayed until weaning is begun a usually occurs between 32 to 79 weeks postpartum with average of 48 weeks. Nursing mothers who supplement early a in increasing amounts usually resume fertility about as quickly non-breast feeders in which ovulation occurs within 36-77 da postpartum. Kippley reponed similar findings from a survey of mothers who ecologically nursed their infants for extended perio of time.

In general, non-breastfeeding mothers have postpartum ameno rhea for only a few weeks, whereas truly lactating women hav amenorrhea for about 9 - 18 months, depending primarily on ho often the infant suckles. The physiological endocrine changes i the mother during ecological breastfeeding stimulate and maintai lactation. More studies are indicated to define better th minimum suckling frequency and duration needed to inhibi ovulation. The preservation of ecological breastfeeding in the developing world and the rediscovering of it in the more developed world should improve child health and help restore more desirable spacing of children.

In 1925. Mahatma Gandhi made the following Statement. "I urge the advocates of artificial methods of birth control to consider the consequences. Any large use of the methods is likely to result in the dissolution of the marriage bond and in free love".

HUMAN LIFE
(A PAEDIATRICIAN'S ADVICE FOR FAMILY LIFE)

Robert L. Jackson, M.D., Department of Paediatrics, Univ, Kansas, 39th and Rainbow Blvd. Kansas City, Kansas 66103. U.S.A.

The family, societies most vital and basic human institution, is being affected adversely by profound and rapid changes resulting from the gradual adopting of unnatural ways of life.

After over fifty years of pediatric clinical experience and fifty years of marriage, it has been my observation that to establish enduring families in our more complex society, it is equally important both for boys and girls to complete their formal basic education and be self sufficient before marriage. After marriage, both will have grave family responsibilities requiring sacrifices for each other. The boy should be a man in a position to support a family and with basic knowledge of reproductive physiology. The girl should be a mature woman with knowledge of her fertility and with sufficient education to support herself and her children should the need arise.

As a pediatrician, my concern has been to help parents accept, love and enjoy their children by learning and understanding good health practices. It also have been my observation that more than anything else, children need unselfish parents. Unselfish meaning a full time mother and a responsible and loving father, during infancy and the critical preschool years when physical growth as well as emotional and intellectual development are proceeding so rapidly.

The first child in any family has inexperienced parents but if the child is wanted and accepted, the parents learn a great deal in a very short period of time. The second child arriving in about two years will not only extend the education of the parents but automatically provides the discipline especially needed by a first child. Three or more children spaced at about two year intervals are desirable for most healthy couples living in a stable environment. The cooperative help of mothers and fathers in families provides the ideal role models for normal sex identification during infancy and the preschool years.

My advice for enriching and stabilizing family life for our youth and for future generations is summarized as follows:

It is very desirable for girls and boys to complete their formal basic education before marriage.

The boy should be a man in a position to support a family and with basic knowledge of reproductive physiology.

The girl should e a mature woman with knowledge of her fertility and with education sufficient to support herself with children should the need arise.

Soon after marriage, it is preferable for most couples to prove their fertility.

For the first nine months of intrauterine life an infant needs a mature well nourished mother.

Labor and birth need to become again a natural and acceptable life experience for both parents.

It is preferable to space children about two years apart by biological breastfeeding and fertility awareness.

Each couple ultimately has to make the grave decision as to how many children they can care for and educate. (I recommend three or more children for healthy couples living in a stable environment. Many mother have told me they cannot understand why their third child is so "good" and such a joy. The simple answer is that this child and future children have loving and experienced parents and siblings).

(For clarity in the following statement, I will refer to the baby as she). Love your baby by feeding her when she is hungry, changing her when she is soiled, and protecting her from all dangers. Enjoy your baby, play with her, talk to her and don't be reluctant to cuddle and handle her. You don't spoil a baby with tender loving care. Learn to know your baby what she likes and dislikes. Each new baby is unique from any other baby who was ever born or ever will be born.

Breastfeed your baby. Biological breastfeeding consists of (a) feeding only human milk for about six months; (b) Suckling on demand day and night (after about 6 to 8 weeks: most full term breastfed infants sleep from the late evening feeding until an early morning feeding, i.e., for about 5 to 6 hours); (c) using no pacifiers

(d) Gradual introduction of only small amounts of selected foods at about six months; (e) Continuation of nursing as the primary source of food for about one year.

The advantages of breastfeeding are:

1. Breastfeeding reinforces mother's and babies love for each other on a regular basis.

2. Prolactin, a hormone is secreted promptly in response to nipple stimulation which calms the mother and also automatically suppresses ovulation.

3. Milk from a healthy mother meets all of the nutritional needs of a full term newborn infant for about the first six months of life.

4. The composition of human milk changes daily (especially during the early critical first months after birth) to meet the rapidly changing needs of a young infant. It's like having a new formula made special for your baby every day.

5. Babies have very strong sucking desires, so nursing will satisfy not only her appetite but also her desire to suckle, and make her unlikely to be fussy; and nursing also makes the mother more calm and motherly.

6. Human milk will protect your baby from may infections. The first milk (colostrum) and early transitional milk contains may anti-infective substances which decrease not only the incidence but also the severity of infections.

7. Breast fed babies have fewer allergies Human milk protects against sensitization to cow's milk, and other nutrients needed by young infants who are bottle fed.

8. Breast fed babies smell better - as : (a) they are less likely to spit up and human milk doesn't smell rancid as does cow's milk. (b) the stools of breast-fed infants are not putrid as are stools of bottle-fed babies and; (c) diapers will not smell like ammonia and cause diaper rash.

9. Breast-fed babies are much less likely to spit-up. vomit or have diarrhea and never are constipated.

10. Babies breast-fed on demand usually are content and much less likely to have colic in the early months and less likely to have emotional problems related to eating and sleeping as they grow older.

11. Human milk is always ready and needs no refrigeration or preparation.

12. Nursing requires only that the mother eat a little more high quality food so it is much less expensive than buying expensive formulas bottles, nipples, etc.,.

13. Breast-fed infants have many less dental problems in later life. ie., less dental caries and malocclusions often requiring very expensive and uncomfortable dental care.

14. "Biological" breast feeding suppresses ovulation and doctors now understand why this happens. Only "token" or partial breastfeeding has been customary in many cultures and we all are aware that this kind of nursing has very limited and unreliable contraceptive effects. If the mother's milk supplies the only food for her baby during the first five to six months and she continues to nurse at frequent intervals as the baby begins to be given only small feedings of selected high quality foods during the second half of the first year. she is very unlikely to begin menstruating and ovulating again until about 9 to 18 months depending on how often the baby suckles and how much milk the mother continues to produce.

As a finale, I synthesize some of my prescriptions for teaching our youth how to understand why it is preferable and more rewarding to live in harmony with nature. Adolescents especially need role models and factual information to help them understand why and how to cope with their normal sexual desires, how to live a fulfilled life in spite of unfulfilled desires, and that the abuse of sex can lead to very serious and never ending problems. After marriage, couples should prove their fertility, and then space their children about two years between births by biological breastfeeding and knowledge of fertility awareness. Both parents need to understand that during pregnancy and for about a year when the baby is truly breastfed the wife does not ovulate, so conceptions are controlled naturally. Consequently, during the early years of married life, sexual abstinence is limited primarily to times of illness or separation. and for about six weeks between births. The period of involutionary changes after birth in a healthy women is shortened considerably by natural birth and by biological breastfeeding. When the couple decides to widen the spacing or to stop having more children. natural conception regulation will still permit them to have new honeymoons every month. and after only a few years they will begin to recognize the symptoms and signs of approaching menopause. Before long the wife will become naturally sterile with intact female organs. Sexual abstinence is much less difficult for a mature unselfish couple with a secure family.

Natural Family Planning in all of its aspects offers the best hope of overcoming the sense of foreboding for the future resulting from the moral vacuum that is enveloping our

civilization. A new peaceful era is attainable if the scientific discoveries and technological advances now available can be applied for constructive rather than for destructive purposes and we modify the distribution of world resources on the basis of social justice in order to permit the emergence of an ecological society. In recent years. there is an increasing realization that we need to revise and extend maternal and child health programs to attain and maintain higher degrees of health.

Observations and experience should teach physicians and other health workers that interfering with natural processes in healthy persons invariably results sooner or later in varying degrees of detectable pathological changes. Our long-term objective should be to have a stable families with healthy children. There will never be too many well-cared-for children in the world. for in the children resides the real hope for a more peaceful future.

" To create is noble, uplifting, inspiring ;
But the moment you seek to gratify the senses
by merely enjoying the creative powers you begin to cheat creation
and to destroy all those higher spiritual forces within you
It can end only in disappointment"

THE INDIAN FAMILY AT THE CROSSROADS

By Dr. (Mrs) Marie Mignon Mascarenhas, Director, CREST , Bangalore

"THE FUTURE OF HUMANITY PASSES BY WAY OF THE FAMILY"
- John Paul II.

1. Family Definition:

"A family is a community of people living together in an environment which is a centre of healing, a place where one can live, where one can admit one's frustrations. stupidities and anger to people who do not have to retaliate. To be oneself without pretence". Family has also been defined as "those related persons who live together within household, usually with common eating or one kitchen". It is experienced and proven that children grow best in an atmosphere of security and affection. and that material attributes can never be substituted for True Love. Love is caring, sharing, needing and giving. and it is only within the many relationships and experience that family life so abundantly provides, that the child, as well as its parents, can individually and together develop into mature persons.

2. Home:

And this is what is precisely the "Home" - which is not just a place where we live but a place where we are understood - the joys we experience today had their birth yesterday. The trage dies we suffer today were apparent in the warning signs of yesterday. Hence for all the 'tomorrows' of our youth we have to prepare ourselves 'today' ; all this is especially true of family life.

3. Different Families:

'Some families are nurturing places where people learn about their abilities, practise giving and receiving love, and dare to dream what they might become'.'Some families are prisons, where people do what they are told, and wait long years for a word of appreciation. or agitate for an opportunity to escape'.

4. What makes the differences?

'The way a family communicates. A word or a look can lock someone in their own world like turning a key. Yet the key that opens the possibilities of our world is still a look or a word. The differences ? - Effective Communication'.

5. The Indian Family.

In the midst of great social, economic and political changes over the centuries. India has a long heritage of stable family life and structure. The spirit of family solidarity has remained a sustaining power, which has provided meaning to the daily lives of our Indian people. Indian families include families which are vastly different from one another as regards religion. culture. temperament and way of life. There are the Hindus who form the majority. and have been living in the country for over 2000 years. There are the Muslims. Christians, Sikhs, Buddhists, Parsis and Jains who came much later.
In each case the family pattern varies. Superimposed on this,

is the silent social transformation taking place in the Indian Family. This is due largely to the process of modernisation. bringing with it educated women breaking away from accepted family traditions and family controls, looking beyond their homes for self-expression, and increasing opportunities for social mobility. There is a shift from the believing family professing moral and religious values, to the secular family with its rational and pragmatic philosophy which leads to its members adopting new goals for themselves and the commu nity,

6. Family Patterns:

The traditional pattern of living in india was that of a joint family whose members were bound together by ties of common ancestry and common property Now in India. we find there are 3 types of family structures:

(a) The Large Joint Family
(b) The Nuclear Family
(c) The Stem or extended Family

7. Social functions of the family:

Concretely. the social functions fulfilled by the modern family are:

a) The provision of food. shelter and other material necessities to sustain life. and provide protection from external danger. a function best fulfilled under conditions of social unity and cooperation.

b) The provision of social togetherness which is the matrix for the affectionate bonds of family relationships.

c) The opportunity to evolve a personal identity, tied to fam identity. this bond of identity providing the psychic integri and strength for meeting new experience.

d) The patterning of sexual roles, which prepares the way f sexual maturation and fulfilment.

e) The training towards integration into social roles, and acceptance of social responsibilites.

f) The cultivation of learning and the support for individua creativity and initiative

Clearly. the configuration of the family determines the forms behaviour that are required in the roles of husband and wif father. mother and child. Mothering and fathering, and the role of the child. acquire specific meaning only within a define family structure Thus. the family moulds the kind of persons needs. in order to carry out its function. and in the process each member reconciles his past conditioning with his preser role expectations. This process is a continuing one, for th psychological identity of a family changes over a period of time and within the framework of this process. each member at times conforms to. and at the other times and within limits, actively alters, these role expectations.

8. Ideal Family Life:

The atmosphere of the home must be such that children ma develop in happiness therein. fully secure in their parents lov and care. A genuine family finds in their home, recreation an a priceless relaxation from outside woes and work. It is a theatre where little children unconsciously are the stellar per formers ; where true homour (without recourse to the shoddy

and suggestive) generates the ready smile and the hearty laugh.The home of a God-centred family is the first and best school wherein education is looked upon as a cooperative task shared by both parents, brothers and sisters in the pre-school years, aided and developed by the professional teacher in school years. A family thus acquires a sense of self-identity. self-esteem and self-value.

9. Family as a unit of society:

"The family is the basic unit of society, with the members of each unit finding mutual fulfilment leading to maturity". This has been said time and again and the nation goes the way the family has trodden. It has, however, been made to appear that the family has no other function except to act as a constituent element of the bigger society. This is not so. since. basically it is a union of its members, and it is the climate of mutual love and generosity, honesty and loyalty. that fashions the lives of the members into mature and caring individuals. The family so constituted has vital and organic links with society, and nourishes it continually, through its role of service to life. It is in the family that the primary values are acquired that are the animating principle of existence and development of society. Thus, far from being closed in on itself, the family is by nature and vocation, open to other families, and undertakes its social role.

"MARRIAGE AND FAMILY ARE A UNION FOR WHICH THERE IS NO SUBSTITUTE. NOTHING CAN TAKE THEIR PLACE. `AS THE FAMILIES ARE - SO WILL MANKIND BE".

SOCIAL ASPECTS OF PROBLEMS OF A GIRL CHILD

Sr.Florence, Diocesan Director, Family Life Centre , Nobili Pastoral Centre, Madurai.

Introduction :

All human beings are equal. But this statement has no relevance in this world. For throughout history, the status of women in society has been below that of men.Many thinkers and other great people have toiled and moiled to remedy this situation but their efforts have made little impact. To identify the social aspects of the problems of a girl child, it is necessary to consider the historical process and economic and moral factors.

Historical Background :

History gives us numerous facts and data about the position of a girl child in society. Girls have been looked down upon by the other sex. and have not been able to enjoy common human rights. let alone privileges. The women of the not-so-long-ago past were virtually slaves to men; no one believed that they nad capabilities other than for housekeeping. In most parts of this country, there has been no notable change in this position

Status of Female Child in Indian Society :

Even in this 20th century. women in India, whether urban, rural or tribal, suffer from the disability of a lower status as compared to men. Male chauvinism deprives women of their rights. Lacking adequate education, they are unable to challenge the system. and have to submit to it. Over the ages, men have maintained as assertive and manipulative power in all spheres of life.

Why does discrimination exist between a Girl & a Boy ?

A girl is an economic drain She is exploited or dispensed wit as a non-person Because she imposes on her family the burde of marriage and dowry expenses, she must be raised from childhoo in financial and physical neglect.Her birth, in many parts of th country. is greeted with silence, even sorrow A boy arrives to th sound of joyous conch shells.

India is the only country in the world where the ratio of women to men has been declining over the years. Discrimination agains women is practised in the following spheres:

- Frequency of breast feeding
- Medical treatment
- Provision of daily requirement
- Social Status
- Privileges and freedom of action
- Education
- Engagement in domestic work
- Birthday or other celebrations

The Tragic Drama of Female Life :

Snuffing out the lives of newborn babies is ultimately the catharsis in the tragic drama of female life in this country. Female infanticide is prevalent in Tamil Nadu's Usilampatti Kallar community. Nearly 80 percent of the female babies born every year become victims of this practice. An estimated 6000 female babies have been poisoned to death in the last decade. A research

shows the justification given for this is that daughters cannot be reared in the Kallar community for the reasons briefly mentioned earlier. Since the women in the community are not educated. they do not understand family planning and other means of birth control, with the result that female infanticide continues to be resorted to.

Conclusion :

Considering all aspects we can conclude that the status of a girl child in the society continuous to decline. Although there is a tremendous improvement in the development of women in recent years in Indian society generally. more attention is needed to rural women.

CARE OF THE GIRL CHILD

Dr. F. Anjuman Ara, Member, N.F.P. Managing Committee, Dhaka Bangladesh

Care of the girl child is very much neglected in our country, Bangladesh. The reason is: girls are thought to be an economic burden and boys as assets for the family, and the country being poor, its scarce resources are spent on boys and not girls. The results is deaths of girl children much higher in number than those of boys. Girls thus suffer from less education, greater malnutrition, less longevity, and own less property and assets. and have a much smaller role in decision-making.

These disabilities of the girl child must be removed and she should receive the same treatment in the family as a boy child. But how is that possible? Measures like income generation, MCH care, education and family planning etc., especially for women are needed. These will ultimately broaden their social and economic horizons and change their attitude towards the girl child. A campaign conducted by "Save the Children" (USA) has shown a dramatic increase in the survival of girl children and improved their nutritional status, etc.

Parents should ensure that their girl child receives proper weaning, food, education, health care, etc. so that she develops into a position from where she can be an asset to her parents, husband, children and in-laws.

GIRL-CHILD - A STRANGLED SEX ?

K.T. Arasu, Project Planner, No.4, 1st Cross Street, Customs Colony, Basant Nagar, Madras.

Synopsis : This paper reviews the status and problems of the girl child in India in the context of the project prifile of "Alternative for India Developments (AID)" and of its experience in rural and tribal areas. particularly in Acharapakkam Block. Chengleput District, Tamil Nadu.

Girl children in India, constituting 130 millions Indians below the age of 20. are perhaps imposing the heaviest of burdens on many parents. What is the reason for this sex prejudice?

Living puppets :

Reflections of the past about girl children are found in Atharvana Veda. It said: "The birth of a girl. grant elsewhere here. grant a boy". The famous dictum of Manu. the Hindu law-giver runs as follows: "A Women must be her father's shadow in childhood. her husband's in her youth. her son's in old age" A Telugu proverb says: "Bringing up a girl is like watering a plant in neighbour's garden". Similar sentiments have been echoed in `Macbeth': "Bring forth men children only an admiring husband tells Lady Macbeth, "for my undaunted mettle should compose nothing but males". There is also a saying: "A Girl should be like water; unresisting. it takes on the shape of the container it is poured into, but has no shape of its own". In India, even today sons are preferred to daughters because son is valued in terms of old age security. economic gain. continuation of the family name. status symbol. social security and social rituals.

Duality of values :

Practices such as "Basav" by which girls are dedicated to the gods and godesses and later become cheap rate prostitutes. are common even today. among lower caste parents without male issue. these practices persist along with infanticide. foeticide, sati. abuse of the girl child and the like.

Sex Ratio :

The sex ratio in India is loaded against the female. as can be seen from the census data The female to male ration which was 980 females . 1000 in 1901 has declined to 933 : 1000 in 1981. The same trend has continued since. From the official data collected recently in Acharapakkam Block. Tamil Nadu. this ratio is 41 : 59 for 100 of the population. This is also reflected in the higher rate of female infant mortality . 131 for female and 123 for male. High rate of female mortality is reported from e.g. Uttar Pradesh and Madhya Pradesh The sample registration bulletin of the Register shows that. in 1978 the death rate of rural female children (0 - 4 age group) was higher even in the richer States like Punjab which recorded its 47% at more than male infant mortality A study in the Punjab (Ms Das Gupta) revealed that infant mortality rate for first children is the same for boys and girls But when a family has already a daugher. the mortality rate for girls is 53% higher than boys. The mortality rate for girls born to young mothers is 71% higher than boys The study also noted that. during the new-born's crucial first year of life. women spend 2-3 times more money on their sons than on daughters. There is also the heavy toll of maternal mortality rate which ranged from 500 - 600 for 100.000 of the population one mother dies in every six minutes. and nearly one half of the deaths occur in the 15 to 20 age group.

According to the preliminary returns of the 1981 census. the number of girls is 4 million fewer than that of boys.

Nutrition and health :

Many studies, as well as our own project profile and the data from a block, has shown the intra-family nutritional variations, differences in health standards, and female-biased morbidity. This discrimination is more patent during periods of scarcity of food and of economic and social calamities.

Educational deprivation:

Bias against girls is evident in school enrollment and drop-out rates in India. The 1981 census shows that 44.33% and 62.07% of the boys in the age group of 5 - 9 and 10 - 14 respectively have attended schools, compared to the female ratio of 32.21% and 39.4%. The gap is glaring in the Northern States. Neglect of girl children in the educational arena was reported by the Planning Commission (84% for boys and 66% for girls). The primary school enrollment data for 1986-87 reveals the gender gap of 2:1 male/female ratio in primary schools. 3:1 in middle schools. This blatant disparity in education was noted by the Kothari Commission also. Our data collected from Acharapakkam Block in Tamil Nadu also shows the same trend (7436 males against 2314 female children for 1986-87) in school enrollment.

Social Victims:

The practice of child marriages still persists. A survey (The Hindu, Sep.11, 1989) records that 44% of women are married between the ages of 15 and 18, and around 8% are girls scarcely out of childhood. Social studies have noted the difference in nurture, social interaction, and even in recreation and dress patterns. Girls are also victims of abuses like rape, abduction, prostitution and bonded child labour.

It is interesting to note in this context that States with lower *per capita* income like Kerala have recorded higher social developments.

State a mute spectator:

Despite constitutional provisions, several laws and regulations, policies and programmes, problems of grave neglect of the girl child has not been checked. Three decades have elapsed since the passing of the U.N. declaration of the Rights of the Girl-Child, one and a half since the adoption of the national policy on children, and one international decade without any notable change in the lot of children. We have now another opportunity in the declaration by SAARC of "Year of the Girl Child".

Alternatives :

To tackle this problem a multifaceted approach is required. A comprehensive and integrated family policy on health, nutrition, education and other psycho-social needs of children is called for. A specific girl-health programme, particularly for the age group of 6 to 18, is required. So far although this is a potential age-group, no such programme has yet been launched. To prepare girls to be as good mothers, to assume other social roles, a multifaceted action plan is required covering sex, health, home, familylife, and social education. It can be of great relevance to set up model schools to promote values of gender equality, 100% school enrolment drive, and people's workshops. Social mobilisation through the mass media should be undertaken to create the requisite attitudinal changes among different sections of the community.

Conclusion :

Einstein said "it is easier to break an atom than a prejudice". The task ahead of us may be herculean one, nevertheless human society owes the child the best it needs to grow and develop as its responsible members. Today's girls are tomorrow's makers of homes, and assets of our nation. We cannot afford to neglect them. They have to be trained to create a new and progressive social order.

FEMALE INFANTICIDE : A PSYCHOLOGICAL ANALYSIS

Rev. Dr. Thomas M. Kottoor, Lecturer in Psychology, B.C.M.College, Kottayam. Kerala

The problem :

Many cases of Female Infanticide have been reported in India. The British discovery of infanticide in India occurred in 1789 among a clan of Rajputs in the eastern part of Uttar Pradesh. The reports by British district officers and other contemporary observers was generally direct female infanticide rather then death by neglect

Scope of the paper :

The discussion in this paper is restricted to Female Neonaticide which is prevalent in rural India. Two recent reports in "India Today" throw light on the outright female infanticide happening in India. The first report says that more than 450 female babies in a year become victims of infanticide among the Kallar community, a group of landless, low caste labourers in Tamil Nadu's Madurai District. The second instance is from Rajasthan, in Jaisalmer District, among the Bhatis. The practices of female infanticide have been uncovered among tribal Todas of Nilgiri Hills, in Uttar Pradesh, Bihar, Punjab and in Kashmir. It is beyond doubt that direct infanticide of female neonates is practised in rural India even today. It is nearly impossible to document this phenomenon due to the extreme privacy of the birth event and the great ease with which a neonate's life may be terminated. An analysis of the trend in sex ratio of this country reveals a continuous decline in the female population.

Under the norms of a civilised society, the deliberate killing of a newly born female is a premeditated, barbaric and cold blooded murder. A certain awareness of this fact is discernible in the "

Pastoral Constitution on the Church in the Modern World" of the Second Vatican Council which reads : "Therefore, from the moment of its conception life must be gaurded with the greatest care, while abortion and infanticide are unspeakable crimes" (Art 51). In infanticide, the following fundamental values are at stake:

1. The recognition of the right of each human being to the most basic conditions of life and to life itself.
2. The protection of this right to live, especially by the society.
3. The preservation of a right understanding of mother hood.
4. Discrimination against women.

The vigour of the above arguments derives from our belief in the dignity of each person and the sanctity of human life.

As we step into the Year of The Girl Child, the incidence of female infanticide has tended to increase rather sharply, with those perpetrating it having little or no qualms about it. The subject of female infanticide can be analysed in the context of economic deprivation, illiteracy, deep-rooted tradition and customs, and most significantly, the negative attitudes towards women in Indian society. The total lack of a feeling of guilt among parents of these female babies clearly points to the fact that they are victims of tradition, of accepted practices in the community, of ignorance and isolation and above all, of poverty. Had the child lived, it would have been ignored and starved and the mother blamed by her husband

and his family and worse still, the future burden of providing dowry for the Girl's marriage would have been a sufficient cause for a feeling of financial insecurity.

What is it that makes a mother kill her girl child, one of her own genre? The crime is committed, but the motivation lay elsewhere, in the psychological Cul De Sac created in her mind by forces beyond her control. The psycho-pathology of infanticide can be studied from various angles.

The Frustration - Aggression Hypothesis :

Almost 20 years after S.Freud proposed the existence of death instinct, a group of academic psychologists formally presented an alternative view of aggression called the frustration - aggression hypothesis. Their hypothesis was that aggression was learned (not instinctive), a drive acquired in response to frustration. The greater the present and accumulated frustration, the stronger the resulting aggressive response. However, they saw the origin of aggressive behaviour in external factors (accumulated frustrating situations) rather than in an aggressive "instinct". When frustration occurs, the first and strongest aggressive impulse is toward its source. When that cannot be executed, the anger and aggression as transferred to members of lesser power, who are not responsible for the aggressor's frustration. It is called scapegoating.

A revision of the frustration - aggression hypothesis proposes an interaction between emotional states and environmental cues. Leonard Berkowitz, maintains that frustration creates a readiness for aggressive acts. Whether this readiness gets translated into overt aggression depends on the presence of a second factor - stimulus cues in the environment.

It is quite true to say that our ordinary Indian woman lives amidst frusrations and conflicts. These various stresses of daily life have become cumulative and lead to the fierce aggressive response of infanticide. Factors from particular cultural patterns, caste norms, prejudices etc. supply other triggering stimuli.

Learned Helplessness Model :

Another way to understand the dynamics of Female Infanticide is to focus on the concept of learned helplessness. The Indian rural family has hopelessely resigned itself to the belief that their female child will be only a liability and an unsurmountable burden in future. They had learned that there is nothing they could do about this state of affairs. Thus infanticide becomes an overt behaviour of the covert helplessness, depression and hopelessness. Unfortunately, there is very little in the environment to persuade them to change their line of thinking.

Attribution Theory :

The Female Infanticide as a social phenomenon can be analysed in the light of the attribution theory. According to the theory, it is difficult to fully understand this type of social behaviour without considering internal and external attributions. To infer causes, we should take into account the "actor", the object of the action, and the setting in which it occurs. The underlying cause of female infanticide can be attributed to an external or an internal cause. Most likely the situational demands are very strong in female infanticide. When situational demands are strong we tend to discount the claims that a person's actions are internally caused. Consequently, the feelings of existential guilt is absent among the "actors" of this crime. The greater the external constraints, it is easier to count the blame on outside demands, and to legitimize the aggression of female infanticide. Some of the case histories

earlier quoted, reveal that the mothers have developed a sense of self inefficacy, a feeling that they have no control over what happens to them. Self-inefficacy will naturally lead to apathy, despondency, a sense of futility, and a feeling that one is a victim of external forces.

Ashis Nandy, agreeing with the psychoanalytic view of Karl Menninger (1942) thinks that women identify themselves with the aggressive male in hostiliy toward females. Female infanticide is a weird expression of maternal neglect, of women's hostility towards womanhood, symbolically towards her own self. Indian social institutions have made her a participant in her own self repudiation and intra-aggression.

Several points need to be emphasized concerning female infanticide in India. There is a strong preference for sons in India, and there are several strong sociocultural reasons for this preference. It is not always associated with poverty because upper castes in North India such as many Rajput and Jat groups have practised female infanticide. The prospect of having to pay large dowries is often the cause of female infanticide but this cannot be generalised. There is evidence of the absence of female infanticide among many groups of Bengal and South India, even when large dowries are the norm in these regions.

Some moderate proposals are suggested to combat this barbaric practice in our country.

1) Educate the boys and their parents to value the girl child as a person in her own right.
2) Help women to face the future by providing supportive services to deal with crisis and stress, and devise plans to inculcate in them a feeling of hope of being able to exercise over their immediate environment.
3) Separate schools for female children in remote rural areas should be established.
4) Methods of enforcement and implementation of the existing laws and regulations against female infanticide should be explored.
5) The Indian population should be sensitized to the existing sad plight of its women folk-illiteracy, dependency, powerlessness-in controlling their lives and bodies. Real life as well as media exposure can be of great value in this campaign. A relentless fight against dehumanising culture is much needed in India.
6) Encourage women to be proud of womanhood. A positive self-image has to be created in them.
7) Special assistances may be granted to families with girls. Developmental programmes, with emphasis on woman should be introduced in rural areas
8) Sacred books, religious and cultural teachings should be reinterpreted, high lighting the worth and dignity of woman as a person.
9) Public opinion should be created to respect and honour women from conception till death. Mass media could be mobilized to remove the ignorance of the people and to stir the consciousness of a wider public.
10) Religious leaders, social workers, voluntary organisations, public health workers throughout the country have to work together against female infanticide so as to maintain the requisite balance in the population.

MATERNAL AWARENESS LEVEL & INFANT MORTALITY:

By Dr.K.Antony, Catholic Hospital Association of India, Secunderabad. A.P.

Introduction :

The Infant Mortality Rate (IMR) is a sensitive and eloquent indicator of the total development of a community.Reduction of IMR is dependent on many factors. The mother of the infant, the most important Primary Health Care workers in child health, cannot be ignored in any of our action plans.

2. Let us look at India, where in comparison with the rest of the world, the maximum number of infants die (27.6% of the total). Though China has got the largest number of under-5 child population (approximately 98 millions, closely followed by India, 95,8 millions), China's share of the world infant mortality is one-third of India's.

Infant Mortality Rates (our of 1000) for Major Indian States, 1978

State	Rural	Urban	Total
Uttar Pradesh	172	110	167
Madhya Pradesh	141	86	135
Orissa	137	80	133
Rajasthan	139	65	129
National Level	136	71	126
Assam	120	86	118
Gujarat	127	88	118
Andhra Pradesh	120	62	112
Haryana	116	59	109
Punjab	111	65	103
Tamil Nadu	120	63	103
Himachal Pradesh	99	52	97
N.E. Region	85	48	84
Maharashtra	84	56	75
Karnataka	81	55	75
Jammu & Kashmir	76	28	70
Kerala	42	26	39

Source : Survey on Infant and Child Mortality, 1979.

3. This Survey shows that rural IMR is higher than the urban. and the IMR of Four States i.e.. U.P..M.P..Orissa and Rajasthan has higher IMR than the National average Bihar also presumably falls into this pattern, but data were not available for technical reasons. Kerala has got the lowest IMR and it was the only state to achieve WHO IMR target for 2000 A.D.

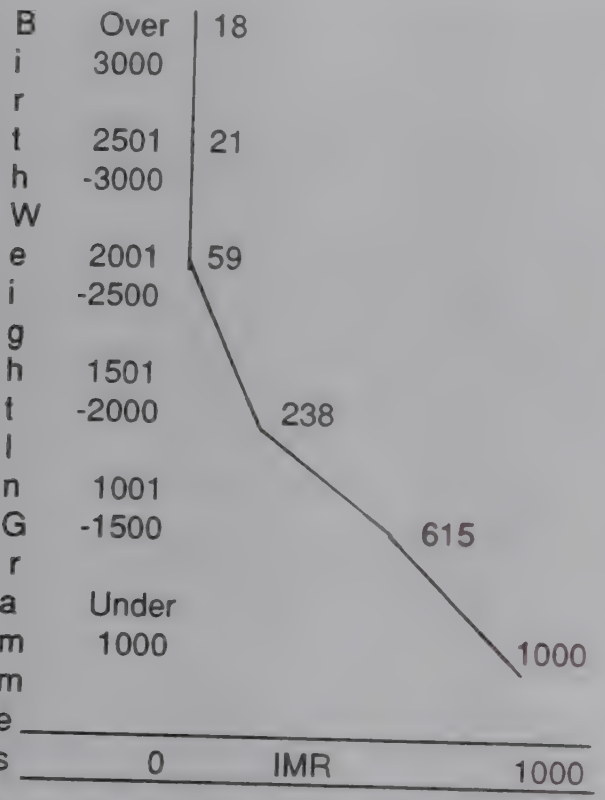
4. Geographically, the world's highest infant killing takes place in Central India, stretching from the desert area of Rajasthan to coastal Orissa, and in the Gangetic Plains of U.P. Bihar. In these regions, the IMR is higher than 126/1000. the national average.

5. Social inequalities, unfair distribution of land and resources leading to low purchasing power for food and health care are main causes for high infant mortality.Prof. Dr. Shanthi Ghosh's study in New Delhi on the relationship between Per Capita income in the family and IMR shows that there is a reduction

of IMR to 1/10th if there is a 10-fold increase in income. However, in Kerala, inspite of a low per capita income, its IMR is not high. The factor which compensates for this handicap of poverty and malnutrition in the survival of infants, is, I believe, the enlightened women of the State.

6. In the following graph, Dr. Ghosh shows the relationship between IMR and Low birth-weight in New Delhi during 1969-74.

INFANT MORTALITY AND LOW BIRTH WEIGHT:



NOTE : Figures for New Delhi, India, 1969-1974.
SOURCE : Ghosh, *et al*, 1978.

Here Dr.Ghosh demonstrates the effect of poverty, and thereby low calories intake, especially during the third trimester of pregnancy, leading to low birth weight and IMR. There is a 1 4th reduction in IMR if birth-weight is raised from 1500 gms to 2000 gms, and a further reduction of 50% if it is raised to 2500 gms.

7. A study done in Bangla Desh shows the relationship between the distance from the clinic and the attendance and mortality in diarrhoeal illness. When the transportation and accessibility to health care centre is poor, it is the awareness of the mother that sets the priority for infant care and mobilizes the family members to pool available resources.

8. A crucial contributory factor to high fertility and high IMR is the young age at which girls are married. If the mother's age is above 20, the IMR comes down drastically in developing countries, like Mexico and Argentina, whereas in the USA, it does not make much of a difference.

9. The following table shows the results of a study made in some Indian states regarding mean age of girls at marriage.

STATE	MEAN AGE AT MARRIAGE
Kerala	21.87
Punjab	21.12
Tamil Nadu	20.25
Andhra Pradesh	17.59
Madhya Pradesh	17.19
Bihar	17.08
Rajasthan (Lowest)	17.02

Kerala had the highest mean age (21.87 years) at marriage

whereas Rajasthan's was the lowest (17.02 years). In Rajasthan child marriages are common. If girls are continuing their education in high schools and colleges, their marriages are postponed.

10. An educated girl has some fertility awareness. She is a co-partner in responsible parenthood from the day she is married. A WHO study among 6541 women in South India over a 5-year period underlines the importance of birth spacing. With a birth interval of less than 1 year, the IMR is twice that of an interval of 2-3 years.

    A study by the Columbia University, New York, shows that the size of the family has a direct relationship with increasing IMR. The risk of infant death increases rapidly after the 3rd or 4th baby in El Salvador and Chile, whereas in England, it makes little difference. Too many and too frequent pregnancies exhaust any women, and this fact is better understood by an educated woman.

11. Increasing levels of maternal education are associated with decreases in the IMR in a community. A study carried out Latin American Demographic Centre shows that a period of seven years of schooling reduces infant mortality by 50%.

INFANT MORTALITY AND LEVEL OF EDUCATION FOR WOMEN - 1978.

Educational Level of women		IMR Rural	IMR Urban
Illiterate		145	88
Literate	Below Primary	101	57
	Above Primary	71	47
Total Literate		90	50

SOURCE: Survey on Infant and Child Mortality, 1979.

Even at the National level there is a lower IMR among the literate mothers group. In India too, there is a 50% reduction of IMR if education is given to women. This is true of both the rural and the urban sectors.

12. According to the 1981 census, the Adult (15 years & above) literacy rate in 14 major Indian States shows a higher national average for men than for women. The disparity is the lowest in Kerala, followed by Punjab.

FEMALE LITERACY AND IMR

STATE	Per Cent female Literates to total female population 1981	IMR 1980 Out of 1000
Kerala	64.48	40
Maharashtra	35.08	75
Punjab	34.14	89
Tamil Nadu	34.12	93
Gujarat	32.21	113
Himachal Pradesh	31.39	87
Karnataka	27.83	71
Haryana	22.23	103
Orissa	21.11	143
Andhra Pradesh	20.52	92
Madhya Pradesh	15.54	142
Uttar Pradesh	14.42	159
Rajasthan	11.32	105

If it will be rear from these figures that there exist a statistically significant correlation between the number of

female literates in a population and its IMR.

13. In conclusion, any child welfare scheme must be coupled with simultaneous "awareness building" among mothers. It is easier to do this if they have schooling above the primary level.

MISUSE OF ABORTION LAW

Dr. M. John Iype
District Family Welfare
Maternity and Child Health Officer
Erode, Periyar District,
Tamilnadu, India

With 3 ghastly examples of foeticide and infanticide. Dr.Iype illustrated the misuse of abortion laws in the country. Often pregnancies will past 5 months are terminated in exchange for monetary benefits. Similarly under the guise of research a racket of infanticide and illegal organ transplants has been operating. The examples quoted by Dr. Iype were:

1. Two cases of 8 months abortions in which the child was killed after the birth
2. A research project where MTP'S were done upto 32 weeks as a study was published in a medical journal.
3. Drugs such as prostaglandins being promoted as abortifacients at any stage.

The shocking cases illustrated by Dr. Iype jolted the audience out of their apathy.

DEATHS DUE TO BURNS IN YOUNG WOMEN

Dr. Mrs. Leela Trived

Deaths due to burns in young women is a burning socia problem of Gujarat State. Most of the deaths took place at th inlaw's place or husband's place. About 10-15 percent of death which occurred at a civil hospital were due to burns. Out of thes deaths, 65% of the deaths were in the age group of 16-25 years which means a sizeable number of young women is liquidate by their own relatives. This is a shocking state of affairs in a stat which boasts of its fast economic development.

Deaths by burns are not common only in the communities where dowry system is prevalent. In other communities where thi is not so, such deaths are also occurring. Such unnatural death of women continue. because they have not brought about an notable resistance to this practice by parents. law makers,an social organisations. These have failed to give timely or adequate help sought by distressed women.

The media are equally to blame for their apathy towards this problem. While every year hundreds of young women are burnt alive, their deaths are reported in a few lines.

In this paper, we are presenting a study of women dying by burns during the last 12 years at the Civil Hospital. Ahmedabad.

The study shows that 15 to 20 per cent of deaths of females were caused by burns in the hospital. Also, there were other deaths of females by strangulation. poisoning. drowning etc.

Our society is so devoid of concern that as much as 20 per cent of our young female population is liquidated by their own

relatives.

Most surprising thing is that a sister-in-law or a mother-in-law does not get burnt due to explosion of stoves or accidents while cooking. It is only a daughter-in-law who gets burnt to death. In the same fashion hundreds of men are cooks in hotels and street eating places but we rarely hear a man dying of such accidents.

About 25% of girls are in the age group of 16 to 20 years, 35% in the age group of 21 -25 and 20% in the age group of 26 to 30 years. While above 30 years is only 25%. By the age of 30 years she is settled in the family and children are grown up, who stand by her.

In Gujarat female education has increased. Girls are doing well in comparison to boys, and men are not tolerating higher education of their wives. Also education of girls has created new names in their life. So they do not accept ..... professions of their husbands which creates disturbances in their married life.

Religion :

Most of the women who have died of burns are Hindus and only 5 percent from other religions. Also, the SATI concept is so conditioned in the Hindu Psyche that the most common method of suicide amongst Hindu women is by burning. Muslims who bury their dead resort to stabbing and strangulation. Among them, however, the killing of women is less prevalent because they marry their relatives. Among Christians, the method is generally poisoning.

Rural & Urban:

That the majority of cases is from urban areas be due to urban populations are not much concerned with their neighbour's problems. In rural areas under-reporting of such killings is common. Some deaths of rural occur in the district and taluka hospitals.

TABLE - I

Socio - Economic

Poor	Middle Income Group	High Income Group	Rich
29%	47%	23%	1%

This menace is more common with the castes where dowry is prevalent and also dowry which was not existing before 25 years has become prevalent in these aspects. It has also become new economic boons in the Rajputs and the Patels and other castes. It was not common amongst Vankers. Most of the women are from middle income group. Though dowry is not prevalent in Brahmins, deaths due to burns are prevalent.

Percentage of burns:

Highest number of burns are above 60% .These are homicidal deaths.

Most surprising thing is that recently we have seen relatives who got burn injuries while going to her rescue and this proves they are homicidal burns.

Place of burning

Inlaw's or husband's place	Parents or relative's home
94%	6%

Only six of the deaths took place at parental or relatives place. They were suicides, because parents were forcing her to go to

inlaw's place but striking difference was that they had to rescue her. In the process relatives had burn injuries on their hands.

We interviewed 94 women who had burns, who survived for 3 to 4 days and who were conscious enough to answer our questions and had less than 60 percent burns. Only young victims between 16 to 18 years were aggressive enough to give the names of their accused in their dying declaration. While some young victims became so resigned towards their parent's pleadings that they refused to name the accused because her own parents did not listen to her complaints and sent her forcibly to inlaw's place.

While women above 20 who had children were warned about their future, and also Hindu women are conditioned from the childhood that a woman has to be submissive and also has to pardon her tormentors, in the process many women said that "God will Punish them" and gave wrong dying declaration of accidents.

In Conclusion:

1. A sizeable young women population is killed by inlaws or forced to commit suicide.
2. Dowry and marital disharmony are main factors.
3. Laws should be enacted where parents should also be punished if they do not give timely help to their daughter.
4. Stringent laws are required to curb the menace of dowry.
5. Special courts should try for speedy judgement.
6. Society is so degenerated that they sympathize with criminals and new obscenity has become a fashion to sympathize with criminals.
7. Special police force to investigate such cases and special courts to prosecute inlaws should be established. Because investigating authority is so corrupt and incompetent. it takes years to get justice and by the time girl's relatives become less aggressive.

DISTURBANCE OF FAMILY LIFE DUE TO PSYCHO-SOCIAL PROBLEMS OF MIDDLE AGED WOMEN - THE ROLE OF FAMILY THERAPY:

Dr. Kanval Mohan
Women's Development Centre
Janki Devi Mahavidyalaya
New Delhi, India

The welfare of woman is systematically neglected from the day she is born. This neglect reaches a peak round middle age, which marks the end of her reproductive life.

The ease with which a woman adapts herself to the changing circumstances of middle age varies widely - in some adjustment is achieved without much difficulty in others, there are serious psychological symptoms.

Those suffering from emotional problems, very often misunderstood, misdiagnosed and inadequately treated, leading to marital discord, violence and suicide. Many women tend to pass into a state of suspended animation. On, spending many useful years of their lives in non-productive social isolation.

Increased urbanisation, travel and mobility, have changed the family structure, ripping women from their traditional support of a wider family, religion, and cultural activities, thus creating a void which alienates them from the mainstream and increases their insecurity.

In a study of 41 women over a period of 10 years, 4 ended their lives, 15 did not receive any kind of treatment or did not comply with the prescribed treatment. Of the 26 patients who were effectively treated, co-operation from the family helped to reduce morbidity caused by marital and family breakdown.

Analysis of the case histories of those who ended their lives or did not comply with treatment revealed the following:

(a) Inability of the family to understand the symptoms and the urgent need for psychiatric intervention.

(b) Medical Practitioners involved with the case failed to recognise the psychological element - treating the irrational behaviour as of nuisance value rather then as a cry for help.

(c) The families were reluctant to accept a psychiatric referral because of the social stigma attached to it.

(d) Failure of psychiatric treatment due to:-

(1) Non-cooperation of the patient.

(2) Inadequate infrastructure and paucity of trained staff.

(3) Treating the woman in isolation.

MODE OF PRESENTATION:

Premorbid personality:

The women affected were of various dispositions rigid, oversensitive, conscientious, hard-working and with a very high sense of duty, a very high moral code, a limited range of interests, poor adult sexual adjustment, difficulty in maintaining friends.

Precipitating factors:

1. Endocrine and metabolic changes associated with the menopause or following hysterectomy.

2. Psycho-social causes:

   (a) Disappointments - especially with children.

   (b) Pre-occupation with might-have-been and missed the opportunities, and unfulfilled ambitions.

   (c) Financial pressures.

   (d) Strains of looking after elderly parents when one's own physical capacity was diminished.

   (e) Lack of purpose - children were growing up and flying away - "empty nest syndrome".

   (f) Pre-occupations with diminished physical attractiveness and fear of being ineffective sexually.

Interestingly these factors formed the content of the patients's

talk - but their removal did not necessarily lead to amelioration of symptoms.

Presentation:

The picture was of a depression without retardation, dominated by feelings of anxiety and unreality. The onset was insidious over a period of several months. The women were aware of their deteriorating mental condition and very often approached for help themselves. Orientation was preserved and memory intact.

In the early stages, they complained of tiredness, easy fatigueability and feelings of inadequacy - "I don't feel like doing anything" - "I will not be able to do it" being the constant refrain. Sleep was disturbed, many hours at night being spent in pacing up and down, coupled with feelings of severe anxiety. As this condition continued, the women became more restless, agitated and uncooperative. There was a tendency to talk over the past, and repeat again and again, in a monotonous way, phrases expressive of their misery.

Feeling of guilt were prominent - there was a tendency in some to blame themselves for some misfortune which had befallen others. One patient felt responsible for the death of her husband's colleague because she had cursed him 20 years earlier. Some had a feeling that they were suffering from some incurable mental or physical disease. One woman suffering from intractable proctalgia, following a piles operation, ended her life because she felt there was no future for her.

Hypochondriacal delusions manifested as an exaggerated pre-occupation with associated physical disabilities, e.g. cervical spondilosis, dyspepsia, chest pain, migraine. There was a tendency to take a lot of medicine - every symptom being treated with a pill.

Paranoid delusions were prominent-husband's fidelity was suspect-very often not without foundation-intentions of friends, neighbours, tenants, viewed with suspicions leading to ugly scenes and embarrassing situations - and frequently to breakdown in relationships.

Physical symptoms:

Throbbing headache, hot flushes, panic attacks, a loss of appetite, fullness after meals, food was refused, leading to a rapid loss of weight.

Constipation was very common symptom causing a lot of misery and distress.

Untreated cases were in danger of:

1. permanent damage in relationships with family and friends, leading to alienation.

2. suicide.

3 contagion - other significant members of the family getting involved, and living in delusional system of the patient, resulting in perpetuation of the condition in space and time.

It is evident from the above that the outcome of the illness depends not only on treating the patient in isolation, but also the resources that can be mobilised to counter the core of the illness. By the time the patient reaches the medical setting, the situation is an acute family crisis - requiring active intervention and a wholistic approach.

Aims of Family Therapy:

1. The patient is approached in her natural habitat, the home.

2. The therapist pitches in with the family, encouraging dialogue in an open, active, forthright way, playing the role of a patient or grandparents.

3. The nature of the disease. its course and outcome, are explained to the family.

4. The individual is reassured and given an opportunity to air out her inner resentments.

5. Milder cases may respond to reassurance and cooperation from the family alone - but the importance of treatment with drugs or electroconvulsive therapy cannot be underestimated. A responsible member from the group is identified, who can take charge of the treatment and ensure compliance.

6. Other members of the family may contribute to fixating the individual in her illness by rewarding her for staying ill, e.g. attention-seeking behaviour being rewarded with compliance. In the family setting, the therapist can identify and suggest more constructive responses.

7. Contagion can be identified and attempts made to control it.

8. It is possible to understand the attitudes of the significant other in the family, e.g., spouse, children etc.,- whether loving and supporting, or hostile and rejecting. In the second situation, it would be better to remove the individual from the family to a hospital or a less hostile environment.

Conclusions:

Involutional problems of middle-aged women are very distressing for the individual and the family as a whole. It is a human problem requiring a wholistic human approach. Family therapy aims at dealing with the immediate problem, and the underlying beliefs and helping the individual to a recovery, with as little social damage as possible, and a decrease in morbidity associated with marital and family breakdown.

References

1. AICKERMAN NATHAN W, M.D. (1973) Family diagnosis and Therapy Page 347-352 (Hand book of psychiatric Therapies Jason arson Inc USA)

2. BENNUN IAN (1986) Some prospects for couples Therapy (Sexual and Marital Therapy Volume I No;2 page 143-153).

3. GOKARL et al (1985) Psycho-sexual Behaviour in Women following Hysterectomy page 81 (Souvenir 7th World Congress of Sexology).

4. NABARRO JOHN (1985) Unrecognised Psychiatric Illness in Medical Patients. Page 7. (BMJ Indian Edition. Volume 1 No:1 Manipal).

1990 - YEAR OF THE GIRL CHILD

Mrs..V.K.Swarna Kumari Arthur
Head, Department of Zoology
St.Theresa's College
Eluru, Andhra-Pradesh, India

As the World is stepping into the 21st century, it is only right that we fight against the abuse and misuse of our resources - human and natural ; women gifted with tenacity, resourcefulness, kindness, intelligence and a host of other virtues should be recognized and encouraged in all fields. The year 1990, having been declared the Year of the Girl Child, should pave the way for development and upliftment of women. This declaration, better late than never, is to remind all humanity that, like a flower, a girl must find a colour, perfume, texture and identity of her own, in order to make her life, and the life of society, meaningful. This year must put an end to the gruesome practices that stifle the potential of the human race.

1979 was designated as the "International Year of the Child" to focus public attention on the fact that family care and protection, health, nutrition, education and recreational facilities are the birthright of every child, whatever its sex.

Girls have suffered considerably in these respects during the past few centuries. Their births have been regarded as liabilities to their parents.

Various social customs that are deep-rooted in Indian society are the cause of this sorry state of girls. One of the major evils of Indian society is the custom of demanding dowry for the marriage of girls. Inability to pay dowry in cash or kind has led to brutal murders of young brides.

There has been a lot of hue and cry over the gruesome SATI incident in Rajasthan in September 1987. The scientific discoveries such as Amniocentesis, chorionbiopsy, Ultrasound, etc., to ascertain possible genetic defects in a baby to be born is being misused by unscrupulous quacks, out to make a quick buck, to identify female foetuses and kill them in thousands.

Mrs. Sudha Tewari, Managing Director of Parivar Seva Sanatha, an organisation dedicated to family welfare programme, says:"All sections of the population, irrespective of their social standing, are hypnotised by this magic wand to eliminate the female child." " Preference for a male child over a female child is universal", says Dr.Neera K. Sohni, Consultant Sociologist, working with the "Ford Foundation", "But unlike in the other societies, we in India dislike, discriminate and in our sub-conscious, blame a girl child for all our misery and misfortune. Religion, tradition, and customs too play their part".

MTP (Medical Termination of Pregnancy) laws are so liberal that it is very difficult to check or detect the culprits of amniocentesis. The clinical professionals in Delhi (for instance) have adopted a policy of keeping the sex of the foetus a secret in any MTP operations.

The consequences of leaving this practice unchecked will lead to an imbalance in male-female sex ratio. Already results are visible in the glaring discrepancy in the ratio in Haryana, Himachal Pradesh and Ladakh.

Government Sociologists and Voluntary Agencies are perturbed over the practice of female foeticide. Although no Government hospital is allowed to provide for this illegal practice, a social worker laments:"The laws which do not get the moral support of society cannot be effective in this vast country."

The Government has constituted a committee of Experts to suggest measures to control the melody. A consultant member of the Committee, Dr.Haldar said that they had evolved a two-pronged strategy to counter this evil; first-ban amniocentesis in toto and make it a criminal offence, except in Government approved teaching and research organisation; and secondly-create awareness among women about themselves. Longstanding social and religious concepts have to be changed."

This may be a long and ardous struggle, but not unachievable. Through the strategy of education, information and communication, barriers and stigmas have to be overcome. Audio-visual media can play a very important role in this. Women have to be projected favourably ; for instance,women police officers, doctors,bankers etc. should be employed on terms equal to those of their male colleagues. The social security aspect of having a female child has to be highlighted. It is an established fact that it is often the daughter, not the son, who comes to the aid of parents during their old age. All traditional, religious and moral leaders should be persuaded to preach, at every gathering, how it is wrong to discriminate between children on the basis of sex.

In Western countries and in some States in India, e.g., Kerala, it has been proved that, with education and enlightment, women can become the anchor for the welfare and well-being of societies and families.

At present there are some institutions providing shelter for the destitute and unwanted children :

1) St. Anne's Charitable Institute in Trichur,Kerala(started in 1923, under the stewardship of Rev.John Kizhekedan) has been a sanctuary of love for women and children who suffer from social disabilities.

2) At Vedaranyam in Tamil Nadu, Kasturiba Gandhi Kanya Gurukulam (started by the late Sardar Vedamtham Pillai in 1946) is a remarkable institution for orphan girls, and is run strictly on Gandhian ideals and principles.

3) In Bombay, Shraddanand Ashram provides care for orphan girls.

The mere declaration of a " Year of the Girl Child" and setting up institutions for unwanted children will not change the system and the thinking pattern of the people, which treats girls as secondary citizens, and will not put an end to female foeticide. Concrete action is necessary, e.g., at Sharmika Vidyapeeth in the University of Hyderabad, which carries on a consistent campaign for the rights of the girl child.

Awareness of the potential of girls begins at one's own home where women play a vital role in shaping the careers of their children. Educational Institutions too can play a vital role in training girls to develop and use their talents and energies so as to become self-supporting, if necessary, in their future life. The Government should also promote this objective by adopting and implementing suitable policies in its various organizations.

OVULATION METHOD OF NFP
A STUDY OF 250 COUPLES (1979 - 81)

Dr. Beena Jena MBBS (Utkal) MSGS (USA), Manipal

1. INTRODUCTION

* Study - Nazereth Hospital
* NFP, MCH Centre
* Outpatient Clinic

2. MATERIAL & SOURCE

* NFP Clinic closely associated with OB.G
* All women in reproductive age group
* All subfertile & infertile groups

3. METHOD

* OM (BILLINGS)
* Abstain, 1st Month
* Observation & recording of Cervical Mucus Pattern
* Recognition of Fertile (oestrogenic) Mucus
* Thin watery, slippery, stretchy-raw egg white
* Recognition of Infertile Mucus (Gestogenic); thick, opaque, sticky
* Temperature Method (B.B.T)- All subfertile women

4. FOLLOW-UP

* Once a week (1st Month)
* Once a fortnight (next 2 months)
* Once a month (4th and 12th months)

5. OBSERVATIONS

A. ACCEPTABILITY

* Motivation & initial instruction - 250
* Acceptance - 100, 40%

NON-ACCEPTANCE - REASONS

* Shyness
* Sexual dicipline (periodic abstinence)
* Doubtful reliability
* Staying apart
* Unpleasant procedure (OBS & REC)

ACCEPTANCE - REASONS

* Strong inclination
* Low sexual active couples
* Intolerance of TV artificial methods
* Husband's cooperation
* Preserve fertility (newly married)
* Spacing of child births - a temporary acceptace
* Subfertility & infertility - management

B. DISTRIBUTION

* Urban	84
* Rural	16

C. SOCIO-ECONOMIC STATUS

* High Income Group	36
* Medium Income Group	64
* Low Income Group	Nil

D. OCCUPATIONAL STATUS

* Housewives	85
* Working women	15

E. EDUCATIONAL STATUS

* Literate 80%, minimum 10 yrs of schooling
* Illiterate 20%, No or very little schooling

F. RELIGION

* Hindus	85
* Sikhs	2
* Christians	2
* Muslims	2

G. AGE GROUP

15 - 20	8
21 - 30	80
31 - 40	12

H. LIVING CHILDREN PER COUPLE

* Nil	32
* 1 child	31
* 2 children	25
* 3 or more children	12

I. OBSTETRICAL & MENSTRUAL STATUS

* Lactating mothers	30
* Regular MC	60
* Irregular MC	10
* Perimenopause	2
* Primary Sterility	30 - 10 conceptions, 5 on fert drug
* Secondary sterility	14 - 5 conceptions, 4 on Lomiphene
* Habitual abortions	3-2 conceptions

J. PREVIOUS METHOD OF FP USED

Method	Couples
* Mucus method	45
* Coitus interruption	24 - most comman
* Condom	20
* Cotraceptive pills	4
* IUCD	3
* MTP	2
* Rhythm	2

K. DROPOUTS - 4

REASONS:

* Continuous mucus discharge (Basic infertile pattern of mucus)	1
* Tubal Uration	
* Lack of husband's cooperation	1

L. FAILURE

* User failure	- 2
* Method failure	Nil

M. SUCCESS

* For achieving conception	47	
Conception occurred	17	
* Avoiding conception	53	
Dropouts	4	
User failure	2	
Successful	47	(95% to 96%)

6. SUMMARY

* A brief report is presented on the study of 250 Women Motivation to follow OM
* Deals with Acceptance & Non acceptance of OM
* Salient Points : Socio-economic, educational and occupational status of users, their religion, age group, OBT & Nent status, Number of living children per couple, previous method of FP used, dropouts, failure & success of OM.

7. CONCLUSION

* Common man is aware of the need of FP
* Few women find learning OM interesting & fascinating
* Majority want an easy way out
* Keen accepters are subfertile & infertile couples
* Doctors find the study of cervical mucus interesting
* Few believe mucus can be successful guideline to fertility control
* Value of OM in the management of subfertility appreciated
* New inventions in FP ----
  - Birth control vaccines
  - Aiviti Progesterone Pill
  - Birth control pill for men

* Artificial methods have complications
* Some couple: Preference for Natural Methods over Artificial Methods

Natural Family Planning - Rural Experience

Mrs. Joyce Jayaseelan
NFP teacher,
Family Welfare & Fertility Study Dept.,
St.John's Medical College & Hospital,
Bangalore - 560034

1. Having devoted considerable thought and study to the subject of Natural Family Planning I can say with confidence, that practicing this method has helped many families, including my own creating trust, harmony, understanding and a healthy family life. I had my training in this method in Bangalore 14 years ago, and in the U.S.A., 4 years ago. I had been following this method for the past 14 years successfully, and with each year, my confidence in it has increased. I am grateful for having learnt it to regulate the size of my family and to have been able to advise many couples on the use of it.

2. I am working in St.John's in the Department of Family Welfare and Fertility Study for the past 7 years. First with Dr.Sr.Lillian and at present with Dr.Augostina Thomas. I have been assisting in conducting training programmes, workshops and classes for various groups, and giving talks on Natural Family Planning(NFP) in and outside the College campus. According to my experience in this field, women, especially in the rural areas, are able to understand NFP easily. As they live in a natural environment, they are able to understand the

association between the changes in nature, and in the body of women, very clearly. For example, when Mother Earth is wet during the monsoon, the farmers sow the seeds because the land is fertile. When they see mucus in the cow dung, they recognise the cow's fertile period, and take the cow for insemination. Similarly, they know that when the woman is wet due to mucus production, conception can take place if she has sexual intercourse during this period. Rural women thus understand NFP better than the urban women.Abstinence is not a big problem for Indian women, because of the Indian culture, and many traditional customs of abstaining during poojas, festivals and marriages. Not only the Hindus but also Muslims have the custom of abstaining during certain days in the year.

3. The rural programme of our Department is carried out in collaboration with the other programmes such as Antenatal check-up, nutrition, mother and child health, and immunization conducted by the Department of Community Medicine. Patients are referred from other departments to our department where we teach the couples this method, either to achieve or to avoid pregnancy. Several of them say after the sessions, "we return from your place with a sense of fulfilment, happiness and satisfaction" , and this gives us great encouragement in our work. This happens especially with infertile couples; even when the woman is normal, and the husband is infertile, the couple suffer from cultural and social pressures. Counselling is given in our Department, for women who wish to conceive as well as to those who would like to postpone pregnancy. The women discuss their problems freely with us.

4. Generally there is need for women to learn their reproductive biology, Natural Family Planning, and Respect for life, so that she can feel the value and fulfilment of her feminity.

1. **Miss Vidya Raman**
   II Year Student
   St. John's Medical College
   Bangalore - India

1. The Girl Child in Indian society was at one time regarded as nothing but a burden on the family, as one more mouth to feed until her marriage, a "Parayadhan", meaning only somebody else's treasure to be safeguarded and given away one day. Today as the role of the women in society assumes new proportions, the need to give the girl child a better deal is being recognised at last. The edicts of the Government are not wholly successful, for new problems are constantly surfacing.

2. I would like to provide but a window into this changing world of a girl child in our society today. From her very birth, a girl is taught that she will always have to settle for second place, for a secondary role to the opposite sex in everyday life. While a male child in the same family would be given better attention, food and clothing, the girl child has to be satisfied with left-overs, helping with the house-work from a very young age and forced to put up with a lot of discrimination, and being told, in no certain terms, that she is an unwanted child. As Mother Teresa has said loneliness and the feeling of being uncared for and unwanted are the greatest poverty. The girl child is often weak, under-nourished, has low physical and mental growth and is thus much more susceptible to disease and infection.

3. The girl's education has a low priority, and not very long ago, any claim the daughter had to the family wealth was given in the form of a dowry, at the time of her marriage, rather than spend on her education. The son was considered a boon, for he would provide an extra pair of hands for work, would add to the family income and moreover support the parents in their old age.

4. Today, the importance of educating a girl child is being stressed, but with this change of outlook comes a new set of problems. As far as the lower economic strata are concerned, efforts are being made to draw girl children to schools by providing them with free education, and in some states free mid-day meal is also provided. But these alone do not suffice. The smart ones go to school only at meal time, and they avail of the facility of the free meal without attending the classes. The main reason for the failure of this scheme is that the parents feel that the children have much greater worth as bread-winners. Girls earn as labourers, construction workers, farm hands, and in addition, help looking after the sibblings in the family. Boys in the family, on the other hand, are often sent to school, even in a situation of dire lack of finances, so that they may secure good jobs later. Education schemes for the girl child, in rural India particularly, can be successfully implemented only if sufficient time is spent initially preparing the ground for it by convincing the common man of the need to educate girl children in today's world.

5. On the other hand, there is the problem faced by parents with highly-educated daughters in finding a suitable match for them. In order to avoid the embarrassment of a situation where the girl is more educated than an eligible bachelor, they are willing to lie about her education in order to get her married. A daughter-in-law is expected to remain a humble, dutiful housewife, and not demand equal rights after marriage. To what end then, is all the college education imparted to a girl with a lot of effort ?

6. The greater proportion of women to men of the same age or social status also becomes a problem when it comes to marriage, with the resulting attitude of a boy's parents being condescending at the very least. They just wait for an opportunity to reject the girl on the most flimsy excuse of a mismatched horoscope or even a vague indication of bad conduct.

Probably also, horoscopes have emerged, as a criterion for match making, as a result of this rat-race for eligible boys in the marriage market. When a girl has a star that does not augur well for her husband or his relatives, her parents have to run from pillar to post to find a groom for her. Such problems are unheard of when it comes to the opposite sex. It seems absurd to use such superstitions as a criterion for marriage, when all it does is to add one more injustice to those already being borne by the girl.

7. The solution for most problems pertaining to the girl children in our country does not lie in passing laws. The real solution lies in the minds of the people, in which awareness has to be created of the existing problems.

II. **Miss Julie Emmanuel**
Class IX,
Sacred Heart Higher Secondary School.
Churchpark,
Madras

1. We speak many languages in our country. In every language of ours, there are proverbs and sayings which expressly state that a girl child is not really important. I will mention here one or two of these :

   In Hindi, we have a saying which means :

   > A girl is the property of another person, so why worry about her ?

   In Telugu, we have a proverb which says :

   > Bringing up a daughter, is like watering a plant in another's garden. So, again why worry about her ?

   From the time a girl child is born, she is discriminated against by society; she is regarded as a property to be discarded.

2. A girl child is not respected. She is subjected to physical abuse, wife battering, brutality of eve teasing, rape and bride-burning. She cannot voice her grievances, and even if she does, most of the time, they are ignored. On the other hand, the son in the family is given food, time to relax, and toys to play with, while the daughter is given the left-overs and made to work from dawn to dusk. She sees this and thinks about it, but if she stops to ask why this is so, she is told :

   "He is a boy. Boys are more important !"

Even her own mother offers her no consolation. So, she swallows the lump in her throat, and carries on with the burden of everyday chores.

3. In some cases, girl children do get to go to school, but how long do they continue with school ? The girl's mother gives birth to another baby, the mother cannot manage both the house work and the baby. She needs help. And who is to help her out ? The little girl who has just joined school. Naturally !! So, the poor little daughter is ordered or cajoled to give up her school and stay at home. Of course, for the good of the family !

4. Let us look at another side of the same story. The new born baby is a girl. There is no rejoicing in the family, only tears. Another piece of property to be disposed of! This little girl will grow up in this world with this kind of outlook in the family She will realise that she is a second class member in the family. She is compelled to accept this fact and put up with the unfair treatment meted out to her. The parents will make sure that she is thoroughly brain-washed into accepting whole-heartedly, this role of her in the family

5. When the girl reaches maturity, she is forced to get married. And, how does a girl get a good husband ? That depends on how much money her parents can scrape together. The more they pay, the better are their chances of finding a well-placed educated bridegroom.. Whether the girl will be loved, cherished or looked after is not a big concern. They must marry her off and that too, into a better-off family. It is like buying a husband for their girl. The heavier their purse is, the better are their chances of getting a "good" groom.

6. After the marriage, what happens ? The girl carries the dowry and goes into the husband's house with a million dreams in her heart, and hoping to be loved and accepted. But what does she encounter ? The suspicious looks of the other members, the frightening mother-in-law who relieves her of all her jewellery, and if the girl's parents fail to pay up all that they promised to, what follows is anything from wife-battering to bride-burning.

7. The injustice is overwhelming. How did this system of cruelty at all start ? Was this so from the beginning of history ? Definitely not ! In the primitive society, a long long time ago, there was no discrimination against women. In fact, women were considered more important. Deities were females. Leaders were women. Women were the ones who made the major decisions because they were the ones who could bring forth the new generation to strengthen the tribe. Even today, among some groups of people in India, and in Tibet, we see that a matriarchal society does exist.

8 In Vedic Society, women were respected. It is expressly stated in our old books that even though Ram, Laxman & Sita lived in close proximity, Laxman never raised his eyes above his brother's wife's feet so that he did not even know her appearance To speak more generally, it was customary for Hindus, when occasion arose, to address an unknown woman, "mother" and not by any other term of salutation. A religious ceremony was never considered complete unless it was performed by both husband and wife. This was our tradition in those long-long-ago days. Somewhere along the line, we lost our respect for women We began to illtreat and exploit them. We began to hate girl children who in fact are the backbone of our society.

What I want to request you today is to think on new lines, develop a new outlook towards girls. Give them LOVE. Give them education. I am not saying that all girls must finish college and work in offices or teach in schools, but she should be free

to choose what to be. If she chooses to be a housewife after training herself to be a teacher, let her do so. And certainly, this woman, who has had education, will be a better homemaker than an uneducated woman. Everything she does in the home will be influenced by the solid training she had received. She will be better suited to bring forth a new generation which is what everyone is clammering for, and hoping to produce.

So,let us not say : "Why educate the girl child ? After all, her place is in the kitchen!"

But let us say : "The home is where the heart is, and so let the homemaker have the best we can give !! "

Gandhiji said : "When you educate a boy, you educate a man, but when you educate a girl, you educate a whole family." How true indeed it is that "the hand that rocks the cradle, rules the world."

And yet, we refuse to acknowledge those hands; we refuse to appreciate what those hands do for us. We even deny them the education that will make them strong and more capable, in doing the work the good Lord has given each one of us to do, in his own divine plan.

So let us decide in our hearts today, to help the girl child, to love her and to cherish her.

III. **Miss Anjali Jayadev**
II Yr. B.A.
M.C.College
Bangalore

1. In the original Sanskrit texts, the creation of woman by Trashtri the vulcan of Hindu mythology, is described thus : "He took the lightness of the leaf, and the glance of the fawn, the gaiety of the sun's rays, and the tears of the mist, the inconsistency of the wind, and the timidity of the hare, the vanity of the peacock, and the softness of the down on the throat of the swallow. He added the harshness of the diamond, the sweet flavour of honey, the cruelty of the tiger, the warmth of the fire and the turtle dove, the chill of the snow, and the chatter of the jay. He melted all these and formed a woman."

2. Then, he made a present of her to man. And she lived unhappily ever after, to be looked upon with condescension by the "en lightened", worshipped as a goddess, yet walloped with regularity, if, as a wife, she does not bring a whopping dowry.

3. A woman since time immemorial has been moulded to fit the male perspective of the "ideal woman". Time has consolidated these images, so that now it is women who themselves perpetuate these myths.

4. The woes of an Indian woman can be unending, be it in the field of marriage, joint family life, dowry, divorce, alimony, abortion, widowhood, education, equality at work, or even on the road.

5. A girl child's fate is often decided even before birth. Ever since the advent of the Amniocentisis test (popularly known as the "sex determiner" test) thousands of female foetuses have been denied the right to live. If the affluent can "choose" their children

in this manner, the same end is realised amongst the poor by gruesome female infanticide. An issue of "India Today" (Oct. 31st '88) tells us that baby girls are often strangulated in the Bhatti tribe of Rajasthan by their own mothers, as other women goad her along.

6. Perhaps the root of this problem is the shocking lack of literacy amongst Indian women today. Education is not merely schooling; it should be broadened in perspective if we can hope to cleanse our society of its various evils. For centuries, the Indian woman was denied even basic education. If her role in society is to change widely, she has to be given a proper educational background. She has to be aware of the opportunities, problems and rewards that she faces as a woman in today's society. Our country needs the capabilities of half of our population - the capabilities of the women, which have remained untapped to a large extent. Think of the plight of girls aged 15 years and below. In the current situation, 140 million who form 20% of our population are uneducated: their potential has gone to waste.

Eve-teasing - The fact that this perversity is punishable as a criminal offence has done little to deter the roadside Romeos, perhaps because number of women are unaware of the measures that can be taken against him. This can certainly be remedied by the use of the powerful tools of the media. The press, T.V. and radio can broadcast information on how to act during such a crisis, and what the penalty can be.

Rape - An uglier and crueller crime against the girl is rape. Often, the physical and psychological and emotional damage cannot be measured and for fear of humiliation and of not being believed, many cases of rape go unreported, but the number reported should be enough to unnerve us.

A great deal can be done about this. Again the media can issue social service advertisements - forcing the disinterested public to acknowledge the realities of rape. Rape crisis centres should be established in cities where immediate help can be provided to the victim. Schools and colleges can do their bit. Most educational institutions have physical education as part of their curriculums. If at some time, girls can be taught the basics of selfdefence it would certainly help. A new breed of confident young women is what our society needs.

Dowry - the practise has led to the torture of brides in many forms including death. In a report in the "Sunday Magazine" it has been shown that on an average, 2 brides are burnt daily in Delhi alone. Another report in the "India Today" says that 87 brides were burnt in Karnataka during 1988.

Society cannot look the other way when one half of it's population is being abused, battered and bruised, and denied basic rights, there has to be a revolution something substantial to remember this situation in its thinking for us to achieve.

IV. **Miss Martha Suneetha**
IX Std.
St. Teresa's High School
Eluru
Andhra Pradesh

1. We are living in a volcanic age. The whole world is rumbling with discontenment and frustration.throwing up white hot lava of hatred and fury. with ever increasing frequency. can we safe guard the life of a girl child in this nuclear age ? My answer is YES. It was already decided in "the year of the Child" in 1979 that the neglect of the girl child is not only the neglect of the nation but that of the humanity itself. Basically the mother has to shape the child in all respects.irrespective of its sex. mere declarations will not change the existing system and thinking pattern of the people and will not stop them from treating girls as secondary citizens. It will not even put an end to female foeticide.

2. I believe, the girls are more efficient than the boys. Dear parents.why do you discard us even before we open our eyes? Are we not flesh and blood? Don't you like to talk to us? We love you and we like to be with you in this world. Please do not go for sex determination test. We are the gift of god to you. Killing us will never solve your social problems. Jesus Christ has said, "let the children come to me for theirs is the kingdom of heaven." Jesus has come to us as a brother and a friend,bringing new hope, fresh attitudes and new beginnings. let us be ready to receive them.

V. **Miss Gloria Woolgers**
Nursing Student
St. Martha's Hospital
Bangalore

1. "Mother let me live don't take my life. Mother let me live you know it isn't right to stop me form being born." These are the few lines taken from a song in which the unborn speaks to its mother. I am sure that most of you present here are aware that this cry of the unborn is mostly of the female foetus.

   Emphasis has to be laid on the fact that a girl child begins her struggle in life right from the time she has been conceived.

2. Female foeticide is on the rise due to improvements in medical technology which make gender identification possible in uterus.The arrival of a girl child into the world is too often an occasion of total depression and despair. Given such an inauspicious star in life, it is no surprise that. the death rate of the female infant averages well over 100/1000 in India. Female infants are on an average breastfed for a shorter time than boys and they are less well fed and less well looked after generally, and when they fall ill, they receive delayed or less efficient medical attention.

3. The average female child in India is thus a second class member in her own home. She not only endures poorer nutrition, health care and education but also less parental affection. less intellectual stimulation and fewer opportunities to learn, travel and develop her personality. She is expected to forego education in order to run the home and look after the younger children and while still a child, she is married off and becomes a mother herself.

4. We have inherited from our fore fathers the culture that it is a family prestige to have male children who would carry on the family name and business.a culture which rejects the birth of a girl because of our prevailing system of dowry. In this changing world of ours it is about time that we break these age old heritage which rejects the girl child. In this dark scenario, the government runs voluntary organisations,and most of all.the church be sensitised to the enormity and immediacy of the problem. This Year of the Girl Child should provide some acceleration to the existing efforts of the few who are fighting for the rights of the girl child. Does it really help for the UN or the AARC to label a year as dedicated to a particular cause? The short answer is "yes". Despite some inevitable expressions of gloom and despair at the end of virtually every such year, the fact remains that the very act of turning the spotlight world wide on a problem, generates some thinking much of the planet,on the problem, at least for the duration of the year.

5. I would like to share a few incidents which I have experienced. These experiences will perhaps give you an insight into the reason why many young females are backward,emotionally unstable or physically handicapped. I know of an incident which occurred a few months ago of a 6 year old girl whose mother gave "tic 20", a pesticide instead of cough syrup. This is by no means a single stray incident, I have personally witnessed and cared for, four such cases, and all these incidents involved baby girls ranging from ages 3 months to 6 years. The reason for these cruel happenings is that another girl would not be of any great use to the family to carry on the name or business of the family or she would mean another fat dowry. In our supposedly changing world, such incidents continue to keep occurring.

6. Another incident which comes very vividly to my mind is one which occurred during my training in Midwifery. During the first delivery case in which I was assisting, it was a new experienc for me to see the woman who was delivering in such pain, whe I stepped out of the labour room for a minute, I was surged b another wave of sympathy to see the lady's husband sweatin and anxiously pacing up and down the corridor.It was only late that I got to know that his anxiety was not due to the condition that his wife was in or that she had a normal baby or not, but tha his first born might be a girl,as it soon turned out to be. This was not the only case where I saw the father disappointed with the birth of a girl. I can remember only a few who actually did not mind whether the baby was a girl or a boy. What is even more horrifying than the husband rejecting the girl child, is the attitude of the mother herself. Many a times as soon as the mother hears the child's cry her first question is -Sister is it a boy or a girl? If it is a boy the expression is full of joy and if it is a girl, then a sad dull expression crosses over her face.

7. In our world today it is the duty of every citizen,and more so ever of every parent to realise and accept the fact that every child born or unborn be it a boy or a girl, is a precious gift of God,given to the parents to love and to cherish.

8. Every parent must realise the value of a girl, right from the time that she is conceived . She has a right to be born. If we listen to that unborn child carefully, we will hear her say:-

"Mother, let me live
I'm a fragile child of God given to you as his precious gift
To nourish and protect until I am strong
And I promise that, some day, I will repay it to you."

VI **Master Ryan Lobo**
Class X, St. Joseph's Boys' High School,
Bangalore

1. The acute problem of discrimination against a girl child is not only confined to the so-called uneducated or illiterate people. but also prevails in economically comfortable families.

2. The person who is mainly responsible for this problem is the WOMAN herself. There exists a seemingly innocent,if not complex set of values which are passed down. and surprisingly it is not the man who is the cause of this "transference of false values" but the woman - the mother.the sister: the mother-in-law. It is often the mother who teaches her daughter not to exploit her potential to the fullest. but to follow strictly the path laid down for her. To many parents. a daughter is a burden to be got rid of as soon as possible. Marrying her off as soon as possible is their set goal. As a child, a girl is taught by example and by treatment that she is to be more of a object than a person. The treatment which is given to her makes her believe that this what she should be.

3. Almost every day we read of dowry deaths and martial harassment in the newspapers. and this too.not infrequently.in the homes of lawyers.doctors.and other educated people. Often the mother-in-law is the main perpetrator. The "man" is only a silent onlooker.

4. In my family.we are three sons. and when my parents adopted my two sisters. a certain educated. supposedly enlightened someone, asked my parents why they were so foolish so as to adopt two daughters as they already had three sons. "why".she said."you will get enough of dowry. so why do you voluntary get daughters to waste it?". One other person said,"Oh, perhaps you wanted girls - so you could dress them up. Our sisters are - much more to us.the boys in the family than that.

5. Are there any remedial measures at the present level of society? What can we do ? Women themselves can break this "vicious chain". Talks and regular classes may be conducted in girls' schools so that these young may realise their full potential. and take pride in their own dignity and womanhood. As brothers, we should stand with respect for our sisters.

6. As a final note. I would like to recite a poem which I composed on the plight of today's girl child. I imagined what it would feel like to be a girl . . . and . . . .

"I am sinking . . into the sediment of a thousand years of flow
like very smoke exists the pain . . . everywhere . . .
Black tendrils of darkness flow thru'clawing, desperate fingers.
Can't see.can't hear . . . it holds me . . . to a world of black grey.
It stings my eyes into forced reflection . . .
It forces me to run . . . but . . . nowhere to hide . . .
So . . . I run into myself . . . deep to my heart . . . until I am lost . . .
I bang on your red walls.heart . . . I bang on your red doors . . .
But I find no key . . . but I find no key . . .
Oh God . . . help me be free . . . make me be free . . .
So I can jump up . . . and touch the sky . . ."

REPORT ON THE MEETING OF THE "SAARC" HELD AT ST.JOHN'S MEDICAL COLLEGE AND HOSPITAL, BANGALORE ,INDIA, ON JANUARY, 1990.

The opportunity afforded by the International Conference on Welfare of Women and Fertility Awareness held at St.John s Medical College & Hospital, Bangalore, India on January 10 - 12th, 1990, which was attended by among others, delegates of the South Asian Association of Regional Co-operation (SAARC) was availed of by them to hold a meeting of SAARC at the College on January 1990.

Mrs. Chonyi Tsering, Executive Director, Tibetan Women's Association, South India, Joined the Group.

2. The meeting was chaired by Mrs. Padma Ramachandran, Head of the Institute of Management in government, Trivandrum, Kerala, India. Each of the delegates and Mrs. Tsering spoke on the social and cultural problems of Girl Childrens in their respective countries. Copies of their speeches on these problems are appended.

I. **Mrs. Bhubaneswari Satyal, Nepal :**
(Executive Secretary of Nepal Children's Organisations Affiliated to the Social Service National Co-Ordination Council, headed by Her Majesty, Queen of Nepal, Nepal)

1. Many authentic studies have proved the existence of parental bias towards the male child in Nepalese society. Sons are considered necessary for death rites, and the continuation of the family. In the absence of a social security system, parents depend on the son, because sons have the duty to look after the parents. The birth of a girl child is not, therefore, an occasion for rejoicing, and discrimination against her begins right at that stage. Girls make the unpaid labour force, and are a liability, with only marriage and making a good housewife as the ultimate goal. She is trained accordingly, to be submissive to the husband and the in-laws. Boys are to visualise themselves to be bread-winners, whereas the girls are inward-looking and feel inferior to their boy counterparts in the family. Social customs such as early marriage, and lack of parental awareness, further intensify this complex of inferiority.

2. 41.11% of the Nepalese population consists of children aged 0 - 14 years. They are undernourished, and have less access to education than boys, for e.g. only 29% of girls reach even the primary school level. However, following the U.N. declaration on children, Nepal has begun to treat girl children as special target groups ; since 1985, legal amenities and mass awareness programmes have been initiated. But only 1397 children benefitted have so far from these programmes, and females are less than half that number.

3. The customs, traditions, ignorance and inadequacies are major obstacles to developmental projects. Some programmes that the SAARC nations can take up are parental education, vocational training, and social reforms.

4. When the year 1990 was declared the year of the girl child, a National Committee was set up in Nepal, which consists

of representatives of the concerned government and non-government agencies, social workers, and of other eminent persons to chalk out suitable programmes, and bring about non-discriminatory policies towards girls.

II. Sr.Teresa Rebeiro, Bangla Desh.

I am teaching at the NFP Unit in coordination with other social work programmes. In Bangla Desh, women do not much like to do social work. It is a small country with a large population of about 110 millions. The land and the people are very fertile. Artificial methods were introduced sometime ago to limit the growth of the population, but Natural Family Planning (NFP) was undertaken only lately. The acceptance of NFP was poor in the beginning. At present, the response is higher. Muslims accepted it better than the groups of the other religions. There are80,000 registered users at present among the poor as well therich. The people accept NFP because it has no side effects and is inexpensive to follow. Those who are following this method are very happy with it. The Billings Ovulation Method is practised successfully.

III. Sr. Ursula, Pakistan

In Pakistan, it is only a small percentage of women, who have access to education ; a few are sent abroad for higher education. Though both boys and girls are prized by parents,. the boy is given primacy in the family.

2. Benazir Bhutto has said that one of her primary goals is to make it possible for girls to have as much access to education, as for boys. However, the fundamentalist approach and practices of Islam make it a challenging task for her. One example is: the Divorce Law which makes it easy for men to divorce, but not for women. Natural Family Planning (NFP) Units in Pakistan are working hard to get NFP accepted. The difficulty is to find a way to educate Muslim men about the benefits of NFP as a means of spacing the births of their childrens.

IV. Bro. Nethathe Singhe, Sri Lanka

Sri Lanka is inhabited by varied mixture of people Sinhalese, Tamils and others. The three major groups are : Sinhalese forming 74% of the total population: Tamils - 18%, Moors 7% : Burghers and others only 1%. It has four important religions : Buddhists form 70%, Hindus 15.5%, Muslims 7.5% and Christians 8%.

2. In Sri Lanka women make up 60% of its 16 million people. Like the rest of their kind in developing world, it is the mother in the house who grows most of the crops, weeds out most of the fields and fetch most of the water. When that work outside the house is done, she lights the fires, cooks meals, cleans compounds, washes clothes, shops for the family's needs, and looks after the aged, the children and the sick. If she has a girl child, she shares this burden with her.

3. No one thinks of the special nutritional requirements of an adolescent girl following the losses from menstruation. The mean age for marriage in Sri Lanka is 24 years, but almost 18% of all women marrying, do so below the age of 19, and though the age of marriage is going up, so is the rate of teenage pregnancies, so that before a girl's body has properly developed for it, she has to service a growing foetus as well. This aggravates nutritional deficiency and causes anaemia and is thus the source of the breeding of

generations of men and women stunted in body and in mind. It is also widely known but little talked out, that the age of menarche often marks the end of a girl's education.

4. Although women are still exploited for work with inadequate remuneration, there has been in recent times with increased numbers of women entering the work force a growing demand for improved working conditions for women. The Sri Lankan girl-child is thus no longer obliged to contemplate a future of bending under a male imposed state of inferiority.

5. By and large, Sri Lankans love their children, whether boys or girls, and give the girls the same treatment as they do to boys and do not resort to abortion of female foetuses or to female infanticide, nor do they worry unduly about having to pay dowries.

V. Rev. Fr. P. Fonseca, India

1. In all SAARC countries the problembs of children, especially girl children, are the same, except in Bhutan and the Maldives, where there is a matriarchal system. The following few points need to be borne in mind in attempting solutions to these problems :

   (a) Free and compulsory education for all girls by the end of 1995

   (b) Minimum age for marriage for girls to be raised to 20,

   (c) Enforcement of women's right of inheritance of land or other property after the death of husband or father.

   (d) Training and empowering of women to react strongly and effectively as a force against evils such as dowry deaths, amniocentesis, female foeticide, rape, wife-battering.

   (e) Strong and effective reaction to the use of nude, or otherwise indecent female figures for advertising in the media, or elsewhere, e.g. posters.

   (f) If a girl child has lost her father, or he is not traceable, she could take on her mother's name.

VI. Mrs. Chonyi Tsering, Tibet

The women in Tibetan Society participate, with almost equal zeal, if not more, with men, in all the spheres of the life of the community in which they live.

Most women do the housekeeping chores in the family. They are also engaged in agriculture and in business, and lately in administration which was entirely a man's sphere in the past. Very few, however, have reached the decision making level in administration. Some have entered various professions such as teaching and medicine.

In marriage, usually the girl goes to the boys's house, but there are instances where the boy comes to the girl's house when there is no son. In the past, arranged marriages were the rule, but in recent times (particularly among those in exile), love marriages have become common. In both cases, before the marriage is solemnized the consent of the parents is sought,

and is essential. In the arranged marriage, an astrologer is also consulted to ascertain whether the marriage will work out or not.

Fortunately, in Tibetan society, there is no dowry system of the kind which exists in India, but the girl's parents give her a few sets of clothes and whatever property they can afford according to their standard of living, to be taken to the boy's house. The boy's parents also send some gifts to the girl's house as a gesture of their appreciation of her having been brought up from childhood to maturity. If, after marriage, the girl is unhappy in the boy's house, she obtains a divorce and returns to her parents. There is no stigma attached to remarriage. Therefore, in Tibetan society, parents don't feel worried even if they have 2 to 3 girls. They prefer to have sons not because it brings them any social status, but because they find it much easier to rear boys.

I have very little idea about family planning practised by women in Tibet but I do know that it is practised mostly by the educated couples in exile. In Tibet , one child for one family is strictly enforced by the authorities on Tibetan couples in her region. Various contraceptives such as IUCD, sheaths, Dutch caps, etc., are used, but these are available only to the privileged classes - the communist party members and government officials as they are painless. For the general public abortions and sterilization are compulsory to fulfil the rule of one child for one family.

Mrs. Padma Ramachandran, Chair person, while concluding the session said :

1. In most of the SAARC countries the girl child is not as welcome as the boy. The state I come from, Kerala, is an exception, a rosy picture seems to emerge. More girls join schools than elsewhere in the country. A study has been taken up to see if this is the real situation, or if there is discrimination against the female child.

2. It was found that the average number of children in a family is two or three. Man is considered the breadwinner of family, though the trend is changing slowly, as the women also go to work for a living.

3. The marriage age for girls is higher in Kerala as compared to other States in India, but marriage is considered necessary for girls. Religious fundamentalism plays an important role on various aspects of life ; religious leaders discuss subjects such as whether a woman can assume leadership roles of the kind described in the well-written book "The trial of Benazir Bhutto".

   These leaders need to have an orientation programme. Women's issues are not realised as societal issues, but as solely women's issues. For example, when it is said there is need for creches, the immediate reaction is - 'oh, they are for working mothers'. In Vietnam, I saw a Day Care Centre for working parents, and this brought up the thought immediately, of the equality of both parents. This idea should be emphasised in all programmes and terminology.

4. When there is an agitation against injustice done to women, only pictures of women are seen. Where are the men in the agitation? Both should take part in such movements. In Kerala, when there is family planning programme, only women attend. The approach of cooperation between husband and wife is important.

5. Some programmes, ie., SAARC nations taking up the improvement of the conditions of girls and women, counselling of parents, vocational training and social reform, particularly in the following directions :

   1. Availability of services to women to have a choice to control their reproductive life
   2. Education
   3. Economic needs

6. Families are becoming nuclear units. Men want working wives regardless of the need of the looking after the children. Men go abroad, leaving women to fend for themselves and their childrens. The Government should take steps to provide care for children, who are deprived of parental care.

YOUNG MAN'S TRYST

By Dr. M.K. Chandrasekhara, Professor & Head of Pediatrics Dept., St. John's Medical College, Bangalore, India.

I love you - you whisper in the dark
to the dainty maiden, but
Do you know, that she is a survivor
of the darkest race ?
Shunned at birth, stunted always
suppressed to too few words,
she is sold in the market.
You get her to work and entertain you,
and bear, bring up, and bow to, your progeny.
And, better than the best bargain on the street,
you get paid, before the wedding.
What price, young man,
have you paid for this mother,
in silent tears, suffering and death.
Or worse still, a living martyr
bearing fruits, withering and bitter ?
What joy in this squalid procession
of your own destiny ?
This year you have a choice
Of Hope or Disdain.
The Year of the Girl Child
to nurture the blossom, to kiss a tender shoot,
the little flash growing into a bundle of joy.
And, the Year of the Horse
Unbridled
to trample the flowers of love,
to slash and burn, the very source of life.
Bridle the Horse, will you ?
Let the Girl Child through. Thank you.

INTERNATIONAL CONFERENCE ON WELFARE OF WOMEN AND FERTILITY AWARENESS JANUARY 10 - 12, 1990.

BRIEF REPORT

In connection with the declaration of 1990 as the 'Year of the Girl Child' by the South Asian Association for Regional Cooperation (SAARC), St. John's Medical College and Hospital, Bangalore, India, celebrated the occasion with a fitting tribute to womanhood, when the Department of Family Welfare & Fertility Study in collaboration with the Department of Obstetrics and Gynaecology, organised an International Conference on 'Welfare of Women and Fertility Awareness' in its stimulating academic premises, from 10 - 12 January 1990, drawing about 200 delegates from SAARC and Countries (List in Appendix) and experts from the USA and Australia.

Objectives of the Conference :

2. Programme

1. The objectives: This International Conference were to impart women with the knowledge of fertility and its natural, scientific control by establishing the credibility of Natural Family Planning by -

   (a) Focussing attention on its scientific basis and its authenticity
   (b) Providing an over view of NFP methods
   (c) Exposing to current research findings on scientific NFP to the scientific world.

2. To conscientize Voluntary Health Organisations in India on the opportunities available at St. John's and other places, to have NFP teachers trained.

3. To highlight the pathetic situations where welfare of woman is trampled upon and their due rights denied, even when she is a child.

The programme drawn up for the Conference appears in the brochure. A number of Committees and Sub-committees were set up to organise the various supplies and services needed to execute this progarmme (List in Appendix - 2).

3. The Conference was inaugurated at 10.00 a.m. on January 10, 1990 by the Chief Minister of Karnataka, the Honourable Shri Veerendra Patil, and was presided over by Most Rev.Dr.Alphonsus Mathias, Archbishop of Bangalore, and President of the Catholic Bishops' Conference of India, The Director of the College and Hospital Rev.Dr.(Fr.) Percival Fernandez, welcomed the dignitaries and the other participants. Dr.Alfred Mascarenhas, Principal of the College spoke briefly, on the history and achievements of the college, and Rev.Fr.Bernard Moras, the Administrator of the Hospital, spoke specifically on the activities of Family Welfare and Fertility Study Department. An account of this Inaugural Function appears in the Appendix to this report which contained summaries of the speeches delivered during the functions.

4. Dr.Sr.Agostina Thomas, the Chief Convenor of the Conference and Head of the Department of Family Welfare and Fertility Study, introduced the theme of the Conference. About a dozen internationally acclaimed experts described and analysed the different aspects of the theme. Another dozen participants presented Short Papers, and Six Teenagers, Five Girls and a Boy, spoke on various social and cultural problems of girl children in India. All these presentations (listed below) have been reproduced verbatim in the brochure.

A. MAIN SPEAKERS :

(1) "The Year of the Girl Child"
Key Note Address : Mrs. Meera Saksena, IAS
Director, Welfare of
Women and Children,
Karnataka State, India.

(2) Symposium on Welfare of women

a. "Gandhiji's Vision for Women" : Dr. Illaben Naik
Assistant Director
Population Education
Research Centre,
Gujarat Vidyapith,
Ahmedabad, India.

b. "Population Education" : Dr. P.B.Desai,
Visiting Professor,
Gujarat Vidyapith,
Gandhi University,
Ahmedabad, India.

3. "The Dignity of Women an Ethical Concern" : Dr. Fr. T. Kalam,
Professor of Bioethics,
St. John's Medical College,
Bangalore, India.

4. "Caring for the Girl Child" : Padma Bhushan
Dr. P.Tirumala Rao
Professor of Paediatrics,
Gandhi Medical College -
Hospital, Hyderabad,India.

5. "The Wellness Approach to Mother & Child" : Mrs. Mary Shivanandan
Director, K.M. Associates,
Maryland, U.S.A.

6. "Nutrition in Adolescents" : Dr. Doren Fredrickson
Community Pediatrics
University of North
Carolina, U. S. A.

7. "Fertility Awareness" Keynote Address : Dr.John Billings,Professor
Emeritus of Neurology,
University of Melbourne &
President of the World
Organisation of the -
Ovulation Method
(WOOMB) of Billings,
Australia.

8. "NFP Work in St. John's" : Dr.(Sr.)Agostina Thomas
Head, Dept. of Family
Welfare & Fertility Study
St. John's Medical College
Hospital, Bangalore, India.

9. "Pilot Studies on NFP in the Public Sector in India" :	Dr. Badri Saxena, Senior Deputy Director General, Indian council of Medical Research (ICMR), New Delhi, India. (Dr.R.Narayanan read this paper)
10. "Cross-Cultural Studies in NFP" :	Dr. Hanna Klaus, Executive Director, NFP Centre of Washington, DC, USA.
11. "Infertility -Male & Femal - Causes and role of NFP in achieving Pregnancy" :	Dr. R. Narayanan, Professor & Head of the Obstetrics and Gynaecology, St. John's Medical College & Hospital, Bangalore, India.
12. "Chromosomal Anomalies in Infertility" :	Dr. Manorama Thomas, Professor & Head, Department of Anatomy & Genetics, St. John's Medical College and Hospital, Bangalore, India.
13. "Cervical Mucus & BBT in treatment of Infertility Cases" :	Dr. Sr. Lillian, Associate Professor Department of Obstetrics and Gynaecology, St. John's Medical College & Hospital, Bangalore, India.
14. "Field Experiences in Teaching NFP" :	Dr. Dara Amar, Professor &Head of the Department of Community Medicine, St. John's Medical College & Hospital, Bangalore, India.
15. "Fertility Awareness and its use - an entry point on Women's development :	Dr. Kathleen Dorairaj, Executive Director/Consultant, Natural Family Planning Association of India (NFPAI),New Delhi, India.
16. "NFP in Ithe 21st Century" :	Dr. Claude Lanctot, Director, International Federation of Family Life Promotion (IFFLP), Washington, U.S.A.
17. "Welfare of Women & Family Planning in the Asian context" :	Dr. Sr. Catherine Bernard, Director, Service & Research Foundation of Asia, (SRFAFC), Madras, India.
18. "Child Spacing through Breast Feeding" :	Dr. R. Jackson, Professor of Paediatrics, University of Kansas, U.S.A.
19. "The Indian Family at the Cross Road" :	Dr. Marie Mignon Mascarenhas, Director, CREST, Bangalore, India.

B. SHORT PAPERS:

The "Short Papers" presented were:

1. "Social aspects of problems of a Girl Child" - Sr.Florence
2. " Care of the Girl Child" - Dr. F.Anjuman Ara
3. " Girl Child - a strangled sex?" - Dr. K.T.Arasu
4. " Review of Unmarried Pregnancies of last fifteen years at the Civil Hospital,Ahmedabad " - Dr. M.B.Shah
5. "Abuses of the Abortion Law" - Dr. M.John Iype
6. " Women's deaths due to burns" - Dr. Leela B. Trivedi

7. " Disruption of Family Life due to psycho-social problems of middle-aged women - the role of family therapy"
- Dr.Kanval Mohan
8. " Maternal Awareness level and Infant Mortality"
- Dr. K.R. Antony
9. " 1990 - Year of the Girl Child" - Mrs. V.K.SwarnaKumari
10. " Ovulation Method of NFP - A study of 250 couples(1979 - 81)"
- Dr.Beena Jena

C. TEENAGE SPEAKERS:

In the course of the Symposium of Teenage Speakers, the following papers were presented:

1. " Problems of a Girl Child" - Miss. Gloria Woolgers
2. " The Status of the Girl Child in India " - Miss. Anjali Jayadev
3. " Problems of the Girl Child - A growing man's Observations"
- Master. Ryan Lobo
4. " How Girl Children are treated in India, nad why education is important for them" - Miss. Julie Emmanuel
5. " The Girl Child in Indian Society" - Miss. Vidya Raman
6. " Steps to be taken to make the Girl Child precious"
- Miss. Martha Suneetha

D. SPEAKERS FROM "SAARC" COUNTRIES AND TIBET:

1. Mrs. Bhuvaneswari Satyal, Nepal
2. Mrs. Choeni, Tibet
3. Sr. Ursula, Pakistan
4. Mrs. Teresa Rebeiro, Bangla Desh
5. Bro. Netha Singhe, Sri Lanka
6. Rev.Fr. P. Fonseca, S.I. India

5. On the last day (January 12, 1990) there was a general session in the course of which, the participants could ask questions to the experts on various issues, and obtain clarifications of them. There was a free discussion which provided an excellent opportunity for academic literaction and dialogue with renowned specialists in the field covered by the Conference, in the course of which , future plans to elevate the status of girl children took shape.

6. The Conference made the following recommendations:

1. To make education for women, atleast upto middle school level, compulsory

2. Non-formal education and job-oriented courses to be concentrated upon

3. Television, Radio and other communication media to stress on issues affecting the girl child such as child labour, dowry, female feoticide in order to bring out attitudinal changes in the society on a massive scale.

4. Sex education .to be given to girls in schools, colleges, and rural areas and in the evenings in the community centres.

5. The Government of India to be urged to adopt NFP as one of its family planning methods.

6. Voluntary agencies, Socio-welfare organisations etc. to strive to create fertility awareness in young women, so that they could themselves plan responsible parenthood.

7. The Conference came to close with a Valedictory Function, a vote of thanks by Dr. Sr.Agostina Thomas, and the singing of

the college Anthem.

8. An interesting feature was the meeting of the SAARC held on the last day, in which, each of the SAARC countries was represented by a delegate who spoke on the social and cultural problems of girl children in his/her country, and suggested solutions for them. A detailed report on the proceedings of this meeting appears in this brochure.

9. The Audio-Visual aids provided for the Conference were much appreciated. The video cassettes presented were on Natural Family Planning and " Six spots on the Girl Child " (UNICEF). UNICEF posters on the problems of girl children were displayed by the Catholic Hospital Association of India, Secunderabad, Andhra Pradesh, India.

10. On the 11th January 1990, the second day of the Conference, there was a cultural programme in the evening followed by a banquet.

11. The refreshments for the three days of the Conference were provided by St. John's, which also met the expenses on travel, board and lodging of the Indian experts and of participants from the rural and tribal areas in India.

12. St.John's is deeply grateful to the following for the assistance given by them to meet the costs of the Conference:

    1. Mr.George Walmsley, Country Director in India, United Nations Foundation for Population Action (UNFPA)

    2. The Bishops of Germany through MISEREOR

    3. Caritas India - through Mr.Christu Raj, Regional Director, Bangalore, India.

    4. UNICEF - through Mr.Das Gupta, Director,Southern Region,Madras. India

    5. Dr. John Billings, Executive Director of the World Organization of the Ovulation Method of Billings (WOOMB), Australia.

    6. Bangalore University through the University Grants Commission, India.

13. The feedback received (vide section "Tributes" in this Brochure) from the participants was overwhelmingly appreciative of the conference having been both academically successful and eminently useful in creating in the participants, the right outlook on Respect for Life, in general and towards girl children in particular.

If I want to become a good citizen
I need a good mother -
Napolean

VOTE OF THANKS

By Dr. Sr. Agostina Thomas, Head of the Department of Family Welfare & Fertility Study
St. John's Medical College & Hospital, Bangalore, India.

Friends, as the Conference is coming to a close, it is my duty to place on record my sincere thanks to all those who helped us to realise this event. You must wonder how a small department and the latest addition to St. John's could hope to accomplish something of this magnitude. It would never have been possible, if it were not for the whole institution of St. John's Medical College and Hospital rising to the occassion as a family and extending full support at every stage of the preparation. Experiencing this feeling of solidarity is so wonderful that it is worth organising a dozen such conferences.

The high quality of contributions and interaction of our informed participants share the credit for the success to a great extent.

Let me thank firstly the Catholic Bishop's Conference of India for patronising the Conference. I thank Fr. Percival Fernandez, the Director of this Institution for his steadfast support from the day we conceived the idea of organising this conference till this moment at every step, advising, appreciating, showing concern and extending support. Thank you Father. I thank Fr. B. Moras, the Administrator of our Hospital who gave me and my department a free hand and told us not worry about the expenses but make the Conference a success and your stay here comfortable.He advised us how to go about various arrangements and his long experience as an administrator contributed a great deal to the success. Thank you Fr. Moras.

Dr. Alfred Mascarenhas, the Principal of the college gave us a valuable ideas on planning the scientific session and agreed to chair the valedictory function. Thank you Dr. Mascarenhas. If we had this hall for our Conference and not a smaller one as planned earlier, it is because of the College Administrator Fr. Ignatius Martiz. He put the artist at our disposal and periodically enquired about the programme the Conference was making. Thank you Father. Fr.Damian, the Deputy Administrative Officer provided accomodation to several of our participants, and took continuous interest in the Conference. Thank you, Father. Dr. Lobo, the Medical Superintendant undertook to invite the Chief Minister of Karnataka to be the Chief Guest.Thank you for all the concern you Showed Dr. Lobo.

Dr.Mario D'souza helped us in the difficult task of preparisng the brochures, contacting the press etc. Thank you Dr. Mario. Finally I am thankful for the involvement and input of the various committees, each of which performed its duty with precision and when each one's part fell into place there was the Conference!

We are fortunate to have eminent scientists, educationists and pioneers in the relevant fields to present high quality papers at the Conference. Dr. Billings of Australia, inspite of his hectic globe trotting schedule to spread the good news of NFP, accepted our invitation most graciously and also donated an amount of Rs. 25.000 towards the expenses of the Conference. Thank you Dr. Billings, we are grateful to Dr. Claude Lanctot, the Executive Director of IFFLP, Dr. Hanna Klaus, Dr.Robert Jackson, Mary Shivanandan, Doreh Fredrickson, Dr. Thirumala Rao and all other eminent speakers. I thank those enthusiastic participants who presented short papers, the six teenagers who brightened the

Conference proceedings by their interesting speeches, and special thanks to delegates from the neighbouring SAARC countries who formed the SAARC team. Thanks to everyone of the chairpersons for performing their duty well and sticking to the time schedule faithfully.

Can you believe that this is our Anatomy Hall? If it is temporarily a Five Star Conference Hall, it is because of efforts put in by Dr.I. Manorama Thomas, Dr. Rajendran and their Team. I can never thank you all and your team enough, dear doctors.

The catering, as all of you have acknowledged was excellent. It is the result of the interest taken by Dr. Nandakumar Jayaram and his team consisting of Dr. Rajendran, Dr.Alapat and Dr. Reginald. Dr. Nandakumar not only made the arrangements, but remained with the participants throughout the meals, to make sure that all was well. My thanks to Dr. Nandakumar and his team.

There was one programme that kept the audience spell bound throughout. It was the cultural programme.Its success is the result of the hard work put in by Dr.Mary Ollapally and Dr.Ashley D'Cruz, thank you doctors. The difficult task of arranging residential accomadation was taken care of by Sr. Ancy and Mrs.Chary. Thank you Sister and Mrs. Chary. I am grateful to Rev.Fathers at Vidya Bhavan for the comfortable accommodation and good food they provided to our participants. I thank the many others whose labour and loving service went a long way to make the Conference a success. It will not be possible to name each and every one, but I must mention a few departments in the Hospital, especially the Accounts, the Central Stores, the Housekeeping, The Dietary, The Enquiry, Maintainance, the Hostel Wardens, the Sisters of Alphonsa Block, Security Officer Major Antony and his men, and the Nursing Superintendents.

I thank the Telephone Operators and the drivers, the Students Section in the college, the Estate Section and the employees of the Anatomy Department, the Artist, the Photographer, the Technicians. Thanks to Santon Printers for the excellent printing work they did and doing it on time too.

My special thanks to the office staff of the Director, Hospital Administrator, the Principal, and the College Administrative Officer, for helping us in various ways. Thank you, announcers, and those who rendered the anthems so melodiously and a big thanks to all the artists, who performed excellently well in the cultural programme. Under the guidance of Dr. Swarna Rekha and Mr. Roy the volunteers became invaluable to the conference. Thank you. Our thanks also to the caterers - All Saints.

Sr. Grace Maria for helping with correspondence in the preparatory stage and Dr. Sr. Valsala for presenting a report on the conference.

There is a lady in Ithis hall, who deserves a big thanks - Mrs. Mary Shivanandan of Maryland, U.S.A. She was with us at the moment the idea of the conference was conceived, though not at this scale then. She had been a source of encouragement and help by introducing several speakers and a couple of funding agencies. Thank you Mary !

It would never have been possible to have hosted this conference, with minimum expense for all of us, if it were not for Ithe generous help given by Mr. George Walmsley of UNFPA, Misereor of Germany, Mr.Christuraj of Caritas India, Dr.Das Gupta of UNICEF, Southern Zone and the Vice Chancellor, Bangalore University thro UGC. I thank all these good people for contributing their share to our effort in conscientising the delegates on the need to practise responsible parenthood and to uplift the status of

the girl child in our region.

Finally, I thank the staff of my department, who worked overtime, at times even forgoing the routine breaks. I told you dear Caroline Joyce, Swarna and Sindhu, that you will make it and you made it. A big hug and thanks to each one of you.

So counting our blessings,

Thanks for what God has done

Thanks for finished work

Thanks for what He expects of us for His Children

Thanks for the desire He has put in us to undertake it

Thanks for friends from far and near

Thanks for bringing us together

Thanks from the heart

Thanks all the time.

DID YOU KNOW ?

- Breastfeeding in the mid 1970s provided more fertility protection in the developing world than all contraceptive programs combined ?

- In developed countries educated women lead in the return to breastfeeding ; in a developing country, educated women lead in giving up breastfeeding ?

- Natural Family Planning may help to predict the return of ovulation in breastfeeding women ?

- Natural Family Planning can aid in the maintenance of a healthy reproductive system ?

TRIBUTES

The Management of St. John's Medical College and Hospital are very grateful for the many letters received, conveying warm sentiments of appreciation of the achievements of the International Conference on "Welfare of Women and Fertility Awareness" organised by the Department of Family Welfare and Fertility Study on January 10 -12 1990, the SAARC year of the Girl Child.. The letters also acknowledged the care that was taken of the personal needs of the invitees during their stay in Bangalore.

Relevant extracts from some of these letters addressed to Dr.Sr.Agostina Thomas. Head of the Department. are reproduced below :

1. I am grateful to God and to St. John's for having organized the International Conference on Welfare of Women, and for having invited me for the same.

   I was much touched by the proceedings, the discipline, the problems of Girl children are legion indeed.

   Before attending the conference I had amniocentesis done, as my in-laws and husband wanted to have abortion done if the child was a female. I have already two daughters. It was decided that I should have the third girl foetus aborted but they said I can wait to return from Bangalore.

   I tell you Doctor, I am keeping my precious daughter come what may. My husband goes along with me now. the inlaws are mum. One day my daughter too will be able to say "My mother chose life" as the girl on your brochure says - with the same joy and pride. One day she will tell the world that her mother's visit to St. John's gave her a chance to live.

   We are happy and at peace, having made the decision. I pray that god may bring many more blessings through St. John's Institution.

   Sincerely & Grateful
   Signed.

   Ps : Keep me anonymous.

2. **Dr. J.J. Billings, Executive Director of WOOMB (The World Organisation of the Ovulation Method of Billings) Australia (25 January 1990).**

   I was very impressed by the Conference. It was an outstanding success and you have every reason to be satisfied with such a fine culmination to the hard work which went into its preparation.

3. **Mr.George Walmsley, Country Director in India, of the United Nations Population Fund, New Delhi addressed to Rev. Fr.B.Moras, Administrator, St. John's Medical College & Hospital, Bangalore, India (22 January 1990).**

   I am writing to convey my appreciation of the effort made by St. John's Medical College and Hospital to organize the recent International Conference on the Welfare of Women and Fertility Awareness. I was particularly impressed by the wide ranging programme that had been prepared and by the quality of tne interventions of the speakers and the participants. The success of the Conference was due in great measure to the organisational support provided by the College and particularly by the dedicated work of Dr. Sr. Agostina Thomas.

4. **Mrs. Mary Shivanandan, K.M. Associates, Bethesda, MD, USA. (9 February 1990).**

There are so many things to thank you for. You did a marvelous job on the conference. Without your talents and energy, which you spent freely, the Conference would not have been half the success it was. I am also very grateful for your friendship and warm heartedness. It is not easy to find selfless people in the NFP field. You are one of them, and it makes all the difficulties much easier to endure.

5. **Dr. Robert L. Jackson, MD, University of Kansas Medical Centre, U.S.A. (29 January 1990).**

It was a great pleasure meeting you and experiencing your dedication to your work. Thanks for all you did for me and Dr. Fredrickson. Keep the faith and persevere in your work.

6. **Padma Bhushan Prof.Dr.P.Thirumala Rao, Executive Director, Cultural Renaissance Society of India, Hyderabad (29 January 90).**

This Seminar has advanced the degree of acceptance of the "Billings method of natural family planning" more than previous session we had 2 years ago at Madras. Of course, every philosopher has to struggle to project his ideas, perhaps his life time, to see that they are accepted. Thus you have done a great service in bringing the natural family planning methods on a wider scale to be accepted in the country replacing many of the other traumatic procedures. So, for this great success, congratulations.

7. **His Highness Prince Aga Khan Shia Imami Ismaili Council for India (letter from Mrs.Hameeda N Allana, Member for Women's Activities (29 January 1990).**

Apart from the excellence and high calibre of the papers presented at the conference, I was greatly inspired by my personal meetings and discussions with the participating members who came from overseas as well as those from SAARC countries, as also, from all over India.

The papers presented were indeed most illuminating and educational in content and I look forward to receiving a transcript of all the deliberations and speeches presented at the Conference at your earliest convenience please. Some of this material, I am sure, could initiate new programmes in our own work with women.

I am confident that the interaction between the various members during the Conference will result in further strengthening and enhancing the important role of women in the realisation of human potential at all levels.

I must add here, that the arrangements made by you and your competent team were superb, and the warmth of your hospitality has left a lasting mark in my memory.

While congratulating you on your competence and the success of this Conference, I wish to thank you again for the personal concern you showed to us during our stay at Bangalore.

8. **Dr. P.B. Desai, Peace Research Centre, Gujarat Vidyapith, (Founded by Mahatma Gandhi), Ahmedabad, (22 January 1990).**

Participation in the Conference was very rewarding, and I do feel that promotion of natural methods, including abstinence, should be transformed into a nation-wide movement. The lack of moral content in our educational system is deplorable. I wish your Department all success in the tremendous task it has taken up.

9. Veeraswamy Hospital, Tiruchirapalli (10 February 1990).

The Conference was highly educative and practical in dealing with Natural Family Planning. Before this, only artificial methods of family planning came to our mind. Now we are very much convinced, to try the Billings Ovulation Method. It is really a wonder that you could organise an international symposium with such eminent speakers to a large audience and without any short comings.

10. Dr. Kanval Mohan, Delhi Cantonment, India (21 January 1990).

The Papers and discussions provided food for thought and helpful to fill many lacunae in one's mind.

11. Mrs. Padma Ramachandran, IAS, Director, Institute of Management in government, Trivandrum, Kerala, India,(20 Jan.1990)

I enjoyed being with you and taking part in the Conference. It was a big success, largely because of you and your attention to detail.

12. Dr.V.Balakrishnan, Tiruchirapalli, India(19 January 1990).

I wish to express my congratulations to you and to the organising committee for the great success of the Conference. The active involvement of the Director, Principal, Hospital Administrator and the committee members helped you a great deal in the successful conduct of the Conference.

The conference is an eye opener for us and I am sure it will go a long way to help us guide our patients in the family welfare programmes.

13. Rev. Fr. Joseph Koikakudy, St.Thomas Apostolic Seminary, Kottayam, Kerala, India (15 January 1990).

The Conference was a big success. I hope you will organize more such seminars, at least on the national level ; St. John's has a definite role to play here.

14. Mr. K.T.Arasu, Literacy Mission of Aid, Alternative for India Development, Madras, India, (20 January 1990).

The Three day conference hosted by your Department will really be ever memorable for me and most other participants. The way the programme planning and operation was done, with total synchronization is a notable feature. I am convinced that Catholic institutions and their band of committed staff have a pride of place not only because of the missionary background but because of the continued infusion of spirituality in very sphere of action.

My heartfelt gratitude for having been provided an opportunity to know that the different dimensions in Natural Family Planning Methods, are not only effective, but the mutual trust they generated between the spouses is also a vital component.

We are, here, going to incorporate Natural Family Planning methods in our education programmes, for which we need to equip our staff. As your organisation is having much experience and expertise, we are going to make use of it in furtherance of our population education. In the forthcoming training programme, kindly give us an opportunity to include some of our staff in this training. We have already registered the name of our organisation with you to seek the expertise

of your Department.

15. Rev. Fr. Thomas Kottoor, B.C.M.College, Kottayam,(1 Feb.90).

Let me first congratulate you on the wonderful Conference. It was very well organised, scientific and informative. The credit goes to you first, the organizing secretary.

16. Sr. Faustina Kannikal, Gynaecologist, St.Jude's Hospital, Sipri, Uttar Pradesh, India. (30th January 1990)

A million thanks to you dear Sister. for giving me this wonderful chance to attend the Conference. It was really a wonderfully well organised and proved to be a fruitful Conference. I really profited much from it. It was a big job accomplished by you and your team. Please extend my thanks to them also. The talks, the accommodation and the meals were really good.

17. Dr. Beena Jena, Kasturba Medical College, Manipal, India. (12th March 1990)

We have most cherished memories of the very successful International Conference on Fertility Awareness. This was possible because of your continuing effort and hard work. We thank you for your kind hospitality.

18. Dr. Fr. Thomas Kalam, Dharmaram College, Bangalore.

"This Conference has brought home to the participants one conviction: that birth regulation should take place in such a way that the dignity of both the women and man is safeguarded. Congratulation to the organizers of the Conference".

ACKNOWLEDGEMENTS

The vote of thanks was proposed by Dr. Sr. Agostina Thomas Convenor of the International Conference on Welfare of Women and Fertility Awareness. held on January 10 - 12, 1990 at St.John's Medical College. Bangalore. (the text of which appears in this brochure) contains the grateful acknowledgements of St.John's Medical College & Hospital. of the contribution made by various persons. in the organization of the Conference. At this subsequent stage of the production of this brochure which contains a comprehensive and voluminous record of the proceedings of the Conference. St.John's Medical College & Hospital is indebted to :

i. Dr. Anil Abraham and Dr. Audrey Lobo who undertook getting the task done. of the transcription of some of the texts from cassettes and later for correcting the proof.

ii. Mrs.Usha Rajan. Stenographer in the Department of Family Welfare & Fertility study. and Mrs.Mary Jayapal. Secretary to Rev.Fr.Ignatius Martis. Administrative officer of the college. who took on a heavy additional load of typing. (Mrs.Jayapal's services were very kindly lent for this purpose by Fr.Martis).

iii. Mr. Willie Saldanha. former Director of Administration of St.John's Medical College & Hospital. who did the compiling of the texts for the brochure. editing them where necessary. and prepared the texts of certain other materials which had to be included in the brochure.

INTERNATIONAL CONFERENCE ON THE WELFARE OF WOMEN AND FERTILITY AWARENESS
St.John's Medical College, Bangalore, India.

DELEGATES

INDIA

1. ANDAMANS

1. Sr. Mary C.Raphael
   Asha Niketan Pilar Clinic
   Lamba Line
   Port Blair - 744 102
   Andamans

2. Sr. Pushpa
   Asha Niketan Pilar Clinic
   Lamba Line
   Port Blair 744 102
   Andamans

2. ANDHRA PRADESH

1. Sr.Alphonse,
   Social Service Centre.
   Gundala,
   Vijayawada - 520005

2. Sr. Aurellia,
   Vijaya Marie Hospital,
   Saifabad,
   Hyderabad - 500004

3. Dr. K.R. Antony,
   Medical Officer,
   Catholic Hospitals
   Association of India,
   PB 2126, Gunrock Enclave,
   Secunderabad - 500003

4. Mr. V.C.R.Arthur,
   Statistical Officer,
   72-B, Ashok Nagar,
   Eluru - 534002

5. Mr. Badri Samuel,
   C.Madaram,
   Khamman District

6. Dr.Consilia,
   Vijay Marie Hospital,
   Safiabad,
   Hyderabad - 500004

7. Sr. Getrude,
   St.Ann's Generalate,
   Kumarapalli,
   Warangal District

8. Rev. Fr. Henry D'Souza.
   Our Lady of Health Church.
   Kairatabad,
   Hyderabad - 500004

9. Dr. Ilka M. Varma,
   153-B-Balamrai,
   Secunderabad - 500003

10. Sr. Lourdus Mary,
    St.Joseph's Hospital,
    Nellore District - 523230

11. Sr. Molly,
    Social Service Centre,
    Vijayawada Diocese,
    Gunadala,
    Vijayawada - 520005

12. Mr.Prabhakar,
    263,Sanjeevareddy Nagar,
    Hyderabad - 500038

13. Dr. Ms. Kishore,
    3-6-756, 13th
    St.Himayat Nagar,
    Hyderabad - 500029

14. Mrs. V.K.Swarna Kumari
    Arthur,
    Head of the Dept. of
    Zoology,
    St. Theresa's College,
    Eluru - 534002

15. Dr. Sr. Thomasina,
    Social Worker,
    Vimala Community
    Development Centre,
    Mariapuram - 516003,
    Cuddapah

16. Dr. Usha Kiran,
    St.Joseph's Hospital,
    Nellore District - 523230

3. GOA

1. Sr. Valentina SFW,
   Holy Family Convent,
   Soncoale - Cortalim

4. GUJARAT

1. Ms. Heidi Wagner,
   SEWA Reception Centre,
   Opp. Victoria Garden,
   Bhadra,
   Ahmedabad - 38001

2. Dr.Leela B.Trivedi,
   47, Professors' Quarters,
   Civil Hospital Campus,
   Ahmedabad - 380016

3. N.K. Mehta,
   SEWA, Badra,
   Ahmedabad - 380001

4. Mr. Preeti Shroff,
   SEWA, Badra,
   Ahmedabad - 380001

5. Mrs.Dr.Rajan Desai,
   Vice President,
   SEWA, Badra,
   Ahmedabad - 380001

6. Sr. Scholostica Apian,
   " Asha Deep "
   Rural Health Centre,
   Unteswamy Mata Mandir,
   P.B.9, KADI -
   Meshana Dt., - 382715

5. KERALA

1. Sr. Dr. Erincheri,
   Gynaecologist,
   St.Vincent De Paul Hospital,
   Ollur,
   Trichur District - 680306

2. Fr. Joseph Koikakudy,
   Professor,
   St.Thomas A. P. Seminary,
   Vadavathoor,
   Kottayam - 686010

3. Sr.Lena,
   San Joe Hospital,
   Perumbavoor - 683542

4. Dr. Mary Kalappurackal,
   Gynaecologist,
   Holy Family Hospital,
   Muthalakodam P.O.,
   Thodupuzha,
   Iddukki District - 686605

5 Sr. Mary Varayathy Karottu,
   Medical Mission Sisters,
   Collectorate P.O.,
   Kottayam - 686002

6 Dr. Padma Ramachandran
   Institute of Management
   in Government,
   Trivandrum - 695033

7. Rev.Fr.RaphaelVadakkan,
   Director,
   Family Apostolate Centre,
   Catholic Bishop's House,
   Trichur - 680005

8. Dr.Sr.Rosaline Colaco,
   Sevanalaya,
   Pambanar P.O.,
   Peermad,
   Idukki Dist - 685537

9. Sr. Rose Vyapana,
   Medical Mission Sisters,
   Collectorate P.O.,
   Kottayam - 686002

10. Ms. Theyamma George,
    Family Life Centre, P.S.C.,
    PALAI - 686575,
    Kottayam District

11. Rev.Dr. Thomas M.Kottur,
    Lecturer in Psychology,
    BCM College,
    Kottayam - 686001

12. Rev. Fr. Thomas Thoppil,
    K.C.B.C.
    Family Commission,
    K.R.F.D. Centre,
    Friendship House,
    Alwaye - 680001

13. Prof.E.D.Varghese,
    Head, Dept. of Botony,
    St.Thomas College,
    Trichur - 680001

14. Sr.Dr. Venma S.D.,
    Alphonsa Hospital,
    Karakutty
    Angamaly - 683576

15. Rev.Fr.Wilson Ukken,
    Professor,
    St.Thomas A.P.Seminary,
    P.B.No.1, Vadavathoor,
    Kottayam - 686010

6. MAHARASHTRA

1. Ms. Cyril Rodrigues,
   5, "Dev-Ashish",
   N.P.Marg,
   Govindnagar,
   Asalphe,
   Ghatkopar,
   Bombay - 400084

2. Mrs. Jennifer D'Souza,
   5, "Dev-Ashish",
   N.P.Marg,
   Govidnagar,
   Asalphe,
   Ghatkopar,
   Bombay - 400084

3. Mrs. Varsha S.Patel,
   Health Edu. & F. Planning
   Dept. of Obtetrics &
   Gynaecology,
   L.T.M.G.Hospital,
   Sion, Bombay - 400022

4. Sr.Theresa,
   Snehasadan,
   Amrut Nagar, Andheri East,
   Bombay - 400093

5. Rev.Fr.F.Fonseca,
   Director,
   Snehasadan,
   Amrut Nagar,
   Andheri East,
   Bombay - 400093

6. Ms.Veena Sippy,
   Flat No.319, 3rd Floor,
   Bombay Market Apartments,
   Tardeo, Bombay - 400034

7. Mr. Hotchand Kirpalani,
   Flat No. 319, 3rd Floor,
   Bombay Market Apartments,
   Tardeo, Bombay - 400034

8. Rev.Dr. Hilary Fernandes,
   Director,
   Jeevan Darshan Kendra,
   Vasai - Bassein - 401201,

9. Dr.Ruth Cerejo,
   Jeevan Darshan Kendra,
   Vasai - Bassein - 401201,

10. Mrs.Leela Pareira,
    Jeevan Darshan Kendra,
    Vasai - Bassein - 401201,

11. Ms.Agatha D'Silva,
    Jeevan Darshan Kendra,
    Vasai - Bassein - 401201,

12. Francina Fernandez,
    Jeevan Darshan Kendra,
    Vasai - Bassein - 401201,

13. Ms.Urmila P.Keskar,
    Vishwaganga Opt
    Dahanukar Colony,
    Gandhi Bhavan Corner,
    Kothrud, Pune - 411029

14. Sr.Aisha,
    Family Welfare Centre,
    1/B, Prince of Wales Drive,
    Pune - 411001

15. Mrs. Hameeda Allona,
    65, Shangrilla,
    Opp.Colaba Post Office,
    Bombay - 400005

16. Sr. Maria Aylagas,
    St. Luke's Hospital,
    Srirampure, Ahmednagar Dt,

17. Sr. Aylagas,
    St.Luke's Hospital,
    Srirampure, Ahmednagar Dt,

7. NEW DELHI

1. Dr.Mrs. Kanval Mohan,
   10,Kirby Place,
   Delhi Cantt.,
   New Delhi - 110010

8. PUNJAB

1. Dr. Lawrence,
   Sacred Heart Hospital,
   G.T.Road,
   MAQSUDAN,
   Jullandar City - 144008

9. RAJASTHAN

1. Dr. G.C.Lodha,
   Director, Health Unit,
   Seva Mandir,
   Udaipur - 313 001

2. Mrs. G. C. Lodha,
   Director, Health Unit,
   Seva Mandir,
   Udaipur - 313 001

10. TAMIL NADU

1. Miss. Shalini Anthayya,
   33, New Avadi Road,
   Kilpauk, Madras - 600010

2. Dr. V. Balakrishnan,
   Veerasamy Hospital,
   B-17, 11th B Cross,
   Thillai Nagar,
   Thiruchirapalli - 620018

3. Dr. Jayalakshmi Dhayalan,
   Veerasamy Hospital,
   B-17, 11th BCross,
   Thillai Nagar,
   Thiruchirapalli - 620018

4. Dr.Vijayakumari Ashok Kumar,
   Veerasamy Hospital ,
   B-17, 11th BCross,
   Thillai Nagar,
   Thiruchirapalli - 620018

5. Sr. Florence,
   Family Life Centre,
   Nobill Pastoral Centre,
   Madurai - 625008

6. Ms. Singamani,
   Holy Cross College,
   Teppakulam Post,
   Thiruchirapalli - 620002

7. Rev. Fr. M.Guruswamy,
   Bishop's House,
   St.Michael's Cathedral,
   P.B.No.6,
   Coimbatore - 641001

8. Sr. Dyana DSS,
   Claretian Mercy Home,
   Ponnamangalam P.O.,
   Thivurangulam,
   Madurai Dt - 626706

9. Sr.Marie Theresa,
   St.Joseph's Hospital,
   Tindivanam,
   South Arcot District - 604002

10. Sr. Cruz Mary,
    St.Anthony's Hospital,
    Pethappampatti,
    Ammapathi P.O.,
    UDNONELPET TK ,
    Coimbatore - 638205

11. Sr. Manika Mary,
    Yesu Bhavan,
    St.Joseph's Social Service
    Centre,
    Usilampatti - 626532,
    Madurai District.

12. Dr. D.Ashok Kumar,
    Asst.Surgeon,
    B-17, 11th B Cross,
    Thillai Nagar,
    Thiruchirapalli - 620018

13. Dr. M. John Iype,
    District Family Welfare
    Maternity & Child Health
    Officer,
    Erode, Periyar District.

14. Mr.K.T. Arasu,
    Project Planner, No.4.,
    I Cross Street,
    Customs Colony,
    Besant Nagar,
    Madras - 600090

15. Rev. Fr. Arokiaswamy,
    Hospital Chaplain
    Catholic Nurses' Guild
    St.Mary's Cathedral,
    Thiruchirapalli - 620001

16. Dr. Vijayakumar,
    Ashok Leyland Ltd.,
    Hosur Industrial Complex P.O.,
    Hosur.
    Tamil Nadu - 635126

17. Sherryn Martin,
    No.1, Goodshepherd Road,
    Thiruchirapalli - 6200001

18. Ms. Christina Mary,
    No., 2B/48, Nurses Quarters,
    Rajaji Hospital,
    Thiruchirapalli - 620001

19. Dr.S.R.Prasad,
    Dayapuram Hospital,
    Manamadurai,
    P.T.T.District - 623606

20. Mrs. Shanthi Mariaraj,
Holy Cross College,
Teppakulam Post,
Thiruchirapalli - 620002

21. Sr. Maria Kamalam,
Holy Cross College.
Teppakulam Post,
Thiruchirapalli - 620002

22. Ms.Sunanda,
c/o K.T. Arasu,
No.4, I Cross Street,
Customs Colony,
Besant Nagar,
Madras - 600090

23. Rev.Fr.Abraham Pothiyittel,
Clarentian Mercy Home,
Ponnamangalam P.O.
Tirumangalam Taluk,
Madurai District - 626706

24. Sr.Elizabeth, SMSSS,
Bagavath Singh Road,
Paramakudi,
Ramnad District - 623707

25. Sr. Dr. Perpetua,
St.Anthony's Hospital,
Madavaram,
Madras

26. Dr. J. Alexander,
Scientific Assistant,
G-6, Meteorological Campus,
50, College Road,
Madras - 600006

27. Mr. Christopher Joseph,
St.Joseph's College,
Teppakulam Post,
Thiruchirapalli - 620002

11.. UTTAR PRADESH

1. Dr.Sr.Faustina Kannikal,
Gynaecologist,
St.Judes Hospital,
Sipri, P.O.,
Jhansi- 284003

12. KARNATAKA,

1. Rev.Fr.Stanley D'Cunha,
Director,
Family Service Centre,
Holy Cross Mission,
Karwar,
North Kanara Dt.- 581306

2. Sr.Adelcia A.C.,
St.Ann's Chapel,
Yodoga Via Haliyal
North Kanara Dt. - 581329.

3. Dr. Jayalakshmi Srinivasan,
179, 11th Main T.K.Layout,
Kuvempunagar,
Mysore- 570023

4. Sr. Amitha,
Concetta Hospital,
Kinnigoli,
South Kanara - 574150

5. Dr. A.Santhosha Shetty,
Project Health Officer,
P.O.Sira - 572137,
Tumkur District

6. Sr. Florence Mathias,
St.Patrao Hospital,
Puttur,
South Kanara Dt.

7. Rev.Fr.Harold F.Pinto,
Director, B.S.S.K,
Bellary - 583104

8. Sr.Naomi,
Good Shepherd Convent,
Bellary - 583102

9. Dr. Kasturi Sjellikeri,
No.133, Type III,
BHEL Nagar,
Kolar Gold Fields - 563115

10. Mr. N.B.Kashappa Goudar,
Dept.of Sociology,
Karnataka University,
Dharwad - 580003

11. Dr. Sr. Philo,
St. Mary's Hospital,
Contonment,
Bellary - 583104

12. Dr.SR.Lillian,
Concetta Hospital,
Kinnigoli,
South Kanara - 574150

13. SR. Gracilda Dias,
Shanthi Dispensary,
Shanthipura,
Kanimeddenahalli Post,
Mysore - 570017

14. Mr.K.Krishnan,
Myrada/Plan, Madakasira
Project. Sira Program,
BARAGUR - 572113,
Sira Taluk, Tumkur Dt.

15. Sr. Mary UFS,
Staff Nurse,
St. Lawrence Rural Health
Centre,
Vijayadka. (via) Kanyana.
Mangalore - 574279

16. Dr. E. Rati Rao.
Scientists.
Micro Biology Discipline,
CFTRI, Mysore - 570013

17. Mr. Chidambar Naik,
50, Azeez Manzil,
Contonment.
Bellary - 583104

18. Rev.Fr. V.T. Paulose, S.J.
Director of Social Work.
Jesuit Nivas, Mundgod.
North Kanara - 581349

19. Mrs. Anandi Martis,
St.Ann's College of
Education,
Mangalore - 575001

20. Dr. Mrs. Beena Jena.
C/o, Prof.P.K.Jena.
Dept. of Surgery,
Kasturba Medical College
P.O., Manipal - 576119,
South Kanara Dt.

21. Dr.P.K.Jena,
Dept.of Surgery,
Kasturba Medical College
P.O..Manipal - 576119.
South Kanara Dt.

22. Dr.Kalsang Phuntso.
Medical Officer.
Dhondeling Hospital P.O.,
Tibetan Settlement.
Kollegal Taluk,
Mysore Dt. - 571457

23. Sr. Pelmo,
Tibetian Medical Centre.
Tibetian Settlement P.O..
Bylakuppe.
Mysore Dt. - 571457

24. Mrs. Choeni Sangmo, SOS
Tibetian Children's Village
School P.O..
Bylakuppe.
Mysore Dt - 571457

25. Sr. Dr.Thadea Daniel.
St. Ignatius Hospital.
Honnavar.
North Kanara Dt.

26. Sr. M. Raymond,
Queen of Apostles Convent.
Vamanjoor Padave - P.O..
Mangalore - 574508

27 Sr.Marina Mathew
Director.
Family Service Centre
C/o.St.Joseph's Convent
Camp. Belgaum -590001

28. Sr.Maria O'Neil.
St.Martha's Hospital .
Bangalore- 560009

29 Dr.E.Jerome.
Lecturer, Dept. of Chemistry.
Christ College. Hosur Road
Bangalore - 560029

30. Dr. A.M. Khan, NIPCCD SRC.
293, 30th Cross, 8th Block.
Jayanagar,
Bangalore - 560082

31. Rev. Fr. Francis Guntipilly.
Jnana Jyothi,
Anekal P.O..
Bangalore - 562106

32. Mr.K.B.Babu,
518. 3rd Cross, 11th Main.
HAL II Stage. Indira Nagar.
Bangalore - 560035

33. Mr.S. K. Arvind,
Research Assistant,
National Institute of Public
Cooperation & Child Devept..
Bangalore - 560082

34 Dr.Jayalakshmi, DGO.
St. Philomina's Hospital.
1.Nilasandra Road,
Bangalore - 560047

35. Dr.Vijayalakshmi,
St.Philomina's Hospital.
1, Nilasandra Road.
Bangalore - 560047

36. Sr.Sicily Chittilapilly,
St.Philomina's Hospital.
1 Nilasandra Raod,
Bangalore - 560047

37. Mrs.Lalitha.
St.Philomina's Hospital,
1, Nilasandra Road.
Bangalore - 560047

38. Dr.Sr.Rosely.
St.Philomina's Hospital,
1,Nilasandra Road.
Bangalore - 560047

39. Dr. Mrs. Krupa Srinivas,
Family Physician,
25, Nanjappa Road,
Shanthi Nagar,
Bangalore - 560027

40. Dr. Sr. Romeo,
Sundeep Training Institute
St. Thomas Town,
Bangalore - 560084

41. Dr. Chitra

42. Sr. Saraphine

43. Dr.Alphonse,
Seva Sadhan Institute,
Koramangala,
Bangalore - 560034

44. Br. Peter Lemos,
Seva Sadhan Institute,
Koramangala,
Bangalore - 560034

45. Dr. Dass P,
Medical Officer of Health,
Doctors' Quarters,
Austin Town,
Bangalore - 560047

46. Dr.H.C.Ramesh,
Dist. Leprosy Officer,
S-S-3,IV "E" Block,
Rajaji Nagar,
Bangalore - 560010

47. Dr.K.A.Shakilaw,
S-S-3, IV "E" Block,
Rajaji Nagar,
Bangalore - 560010

48. Dr.Mrs.Zarina Mehkri,
Dept.of OB & GYNE,
73, Lalbagh Road,
Bangalore - 560027

49 Mrs.Indumathi Rao,
728, 10th Main, 4th Block,
Jayanagar,
Bangalore- 560011

50. Mrs.Margaret Joseph,
9/2, Central Street,
Swathi Road Cross,
Shanthi Nagar,
Bangalore - 560027

51 Mrs. Annamma Joseph,
9/2, Central Street, 27,
Swathi Road Cross,
Shanthi Nagar,
Bangalore - 560027

52. Ms.Vani Deshikachar,
Co-ordinator, Seva-in-Action,
728,10th Main, 4th Block,
JayaNagar,
Bangalore - 560011

53. Dr.Mrs.Kartha,
Seva-in-Action,
728,10th Main 4th Block,
Jayanagar,
Bangalore - 560011

54. Ms.P.Rose Mary,
H.No.54-A,
Ramamurthinagar,
Doorvaninagar
Bangalore 560016.

55 Dr.Archana,
Ursuline Convent,
26, Davis Road,
Bangalore - 560084

56. Dr. A.D. Nagarajan, M D,DCH,
Paediatrician,
613,III Cross, III Block,
Koramangala,
Bangalore - 560034

57. Sr.Mareena,
St. Martha's Hospital,
Bangalore - 560009

58. Sr.Teresa,
Marianville,
Good Shepherd Convent,
Bangalore - 560025

59. Sr. M.Annuntiata,
Secretary,
National Assoc. of Respect
for Life,
Bangalore - 560025

60. Mr. Hugh de Nazareth,
President, National Assoc.
for Respect for Life,
Good Shepherd Provicialate,
Museum Road,
Bangalore - 560025

61. Mrs. Phyllis Farias,
National Assoc. for Respect
for Life, Good Shepherd
Provicialate, Museum Road,
Bangalore - 560025

62. Dr.Chitra Nagaraj,
215,(new) West Park Road,
Baton 162, 17th Cross,
Malleswaram,
Bangalore - 560055

63. Dr. Usha Ramkumar,
Institute for Social &
Economic Exchange
Education Unit,
Bangalore - 560072

64. Ms. Mabel Koilpillai,
Asst. Prof. of Sociology,
Nagarbhai Post,
Bangalore - 560072

65. Dr. Mir. Abdul Latefe,
Kempegowda Medical
Institute ,
Banashankari II Stage,
Bangalore - 560070

66. Dr.Padmini Isaac,
Dept. of OB & GYNE,
St. Maratha's Hospital,
Bangalore - 560009

67. Mrs. Shoba Louis,
Jeeva Jyothi United Printers,
4, Centre Street,
Shanthinagar,
Bangalore - 560027.

68. Sr. Angeline,
Srs. of Mary Immaculate,
88, Benson Cross,
Benson Town,
Bangalore - 560046

69. Mr. Nethatha Singh,
Kristu Jyothi College,
Bangalore- 560036

70. Sr. Rosete,
Srs. of Mary Immaculate,
88, Benson Cross,
Benson Town,
Bangalore - 560046

71. Sr. Cynthia Gonsalves,
St. Joseph's College,
Bangalore - 560001.

72. Sr. Sophia Thomas, MCH,
Bangalore Multi purpose
Social Service Society,
Archbishop's House,
18. Millers Road,
Bangalore - 560046.

73. Dr. Subha V.Hegde,
2-A, 'Ashwini',
19th 'C' Main, 1st Block
Rajajinagar,
Bangalore - 560010.

74. Dr.Amarnath,
Medical Practitioner,
Sneha Bhavan Dispensary,
Viveknagar,
Bangalore - 560047.

75. Sr. M. Alis, M.Sc.,
Staff Nurse,
Sneha Bhavan Dispensary,
Viveknagar,
Bangalore - 560047.

76. Sr. Mercy Abraham,
School of Nursing,
St. Martha's Hospital,
Bangalore - 560009.

77. Mrs. Subhashini,
Lecturer in Economics,
St. Joseph's College,
Bangalore - 560001.

78. Sr. Angela,
Stella Maris Convent,
Sadashiva Nagar,
Bangalore - 560003.

79. Sr. Theresa Mari,
Stella Maris Convent,
Shadashiva Nagar,
Bangalore - 560003.

80. Dr. Mrs. S. Narendran,
Paediatric Consultant,
716, 7th Main,
J.P.Nagar 3rd Phase,
Bangalore - 560078.

81. Prof. Mumtaz Ali Khan,
I 'C' Main Road,
Gangenahalli Extension
Bangalore - 560032.

82. Mr. J. John Baptist,
No: 8. 'C' I Cross,
Hennur Road,
St.Thomas Town,
Bangalore - 560084.

83. Mrs. Kumari Baptist,
No:8, 'C' I Cross,
Hennur Road,
Bangalore - 560084.

84. Mrs. Ann Bina Gosh,
9/2, Central Street,
Swasthi Road Cross,
Shantinagar,
Bangalore - 560027.

85. Sr. Carmino D'Souza,
Our Lady of Health Centre,
R.V.College Post,
Bangalore - 560059.

86. Dr. Annamma Thomas,
Karunalayam Hospital,
58, V Block,
Koramangala,
Bangalore - 560034.

87. Sr. Cross Mary,
Srs. of Charity of St.Anne,
127, Charles Campbell Road,
Cox Town,
Bangalore - 560005.

88. Ms. Helen, CREST,
14, High Street,
Bangalore - 560005.

89. Dr. S.K. Galagali,
Deputy Director ,
Government of Karnataka,
D.H.F.W.P.S.,
Bangalore - 560009.

St. John's Medical College & Hospital,
BANGALORE - 560034. INDIA.

90. Dr. Rana Samuel.
91. Dr. Adrian D'Mello.
92. Dr. Anil Abraham.
93. Dr. Leo Gounalan.
94. Dr. Raju Paul.
95. Dr. Prakash Zacharias.
96. Dr. Victor.
97. Dr. Regi Koshy, Opthomology.
98. Dr. Sr. Valsala.
99. Dr. Sr. Mary John.
100. Dr. Sr. Lucy.
101. Dr. Mrs. Usha Thomas.
102. Dr. Miss. Savithri Ramaiah.
103. Sr. Hubert.
104. Mr. Sabhapathy Naidu.
105. Mrs. Mary Kutty Augustin.
106. Ms. Nirajakshi.
107. Mrs.Joyce Jayaseelan.
108. Mrs. Caroline Santhan.
109. Ms. Swarna.
110. Ms.Sindhu Augustine.

Note : Addresses of some participants who registered on the spot were not recorded by them and are, therefore, not available.

13. BANGLADESH

1. Dr. F.Anjuman) NFP Centre,
2. Sr. Ann Hembrom) 43, East Tejturi Bazaar
3. Mr. Eric DE'Cruz) Telgnon,
4. Ms. Lilly Gomes) Bangla Desh
5. Mrs. Teresa Rebeiro) Dhaka

14. NEPAL

1. Mrs. Bhubaneswari Satyal,
   Executive Secretary,
   Nepal Children Organisation,
   Bal Mandir, Naxal.

INTERNATIONAL CONFERENCE ON " WELFARE OF WOMEN AND FERTILITY AWARENESS" (January 10 - 12, 1990).

PLANNING COMMITTEE:

Patrons : The C B C I Society for Medical Education, India.

Rev.Dr.(Fr.) P. Fernandez,
Director,
St. John's Medical College & Hospital.
Bangalore.

Dr. A.F.M. Mascarenhas,
Principal,
St. John's Medical College & Hospital.
Bangalore.

Rev. Fr. B. Moras,
Administrator,
St.John's Medical College & Hospital,
Bangalore.

Dr. Sr. Agostina Thomas,
Organising Secretary.

Members

Dr. Lawrence Lobo
Dr. Mario D'Souza
Dr. Manorama Thomas
Dr. R. Narayan
Dr. NandaKumar Jayaram
Dr. Dara Amar
Dr. Swarna Rekha
Dr. A. Lillian
Dr. Mary Ollapally
Dr Ashley D'Cruz
Dr. Arun Mhasker
Dr. Rajendran
Sr. Ancy.

Sub - Committees

1. **Scientific Committee:**

   Dr. R. Narayan.
   Dr. Swarna Rekha.
   Dr. Agostina Thomas.

2. **Venue :**

   Dr. I. Manorama Thomas.
   Dr. Rajendran & Team.

3. **Catering :**

   Dr. Nandakumar Jayaram.
   Dr. Rajendran
   Dr. J. Alapatt.

4. Cultural Programme:

Dr. Mary Ollapally.
Dr. Ashley D'Cruz.

5. Accomodation :

Sr. Ancy.
Mrs. Padma Chary.

6. Transportation :

Dr. Nityananda Shetty and his team of young doctors.

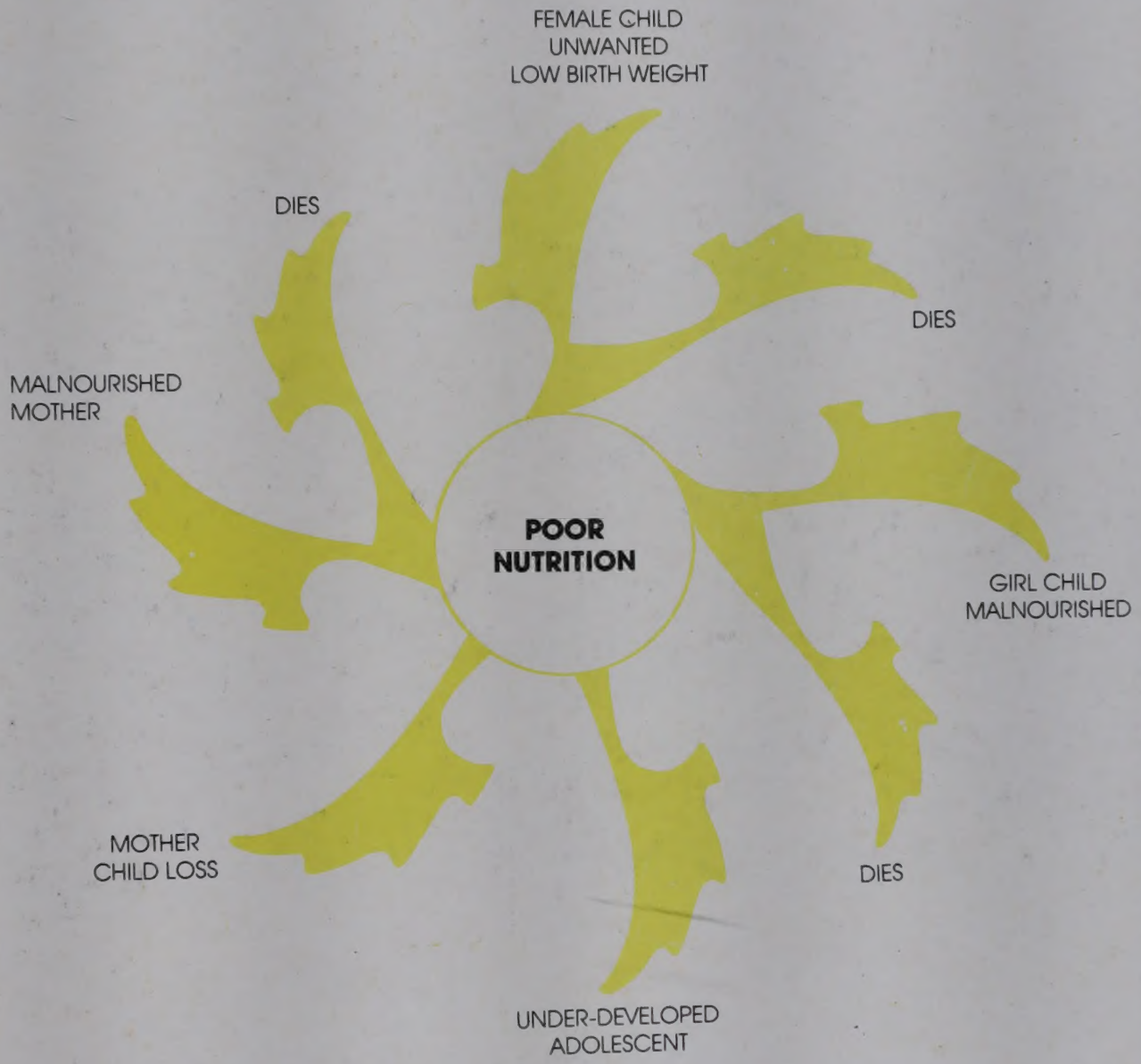
7. Reception :

Mrs. Joyce Jayaseelan.
Miss. I. E. Swarna.
Mrs. Caroline Santhanam.
Miss. Sindhu Augustin.

8. Volunteers-in-charge :

Mr. A.K. Roy.
Dr. Swarna Rekha.

NUTRITION DEPLETION CYCLE



Source : Meera Chatterjee, Both Gender and Age Against Them : Mimeo Report, NIPCCD, New Delhi. 1988.

St. John's Medical College & Hospital Complex *1963*

Silver Jubilee Year *1988*